Employee Partners Care Foundation Request Form

EP Name:				Club Number:			
Club Name:				Club Phone Number:			
General Manager:				Club Fax Number:			
Employee Partner Information							
Position:				**If EP is not married, does he/she:**			
Date of Hire:				❑ Live Alone		❑ Live w/Roommate	
❑ Hourly		❑ Full-Time		❑ Live w/Family			
❑ Salary		❑ Part-Time					
Is Employee Partner married?				❑ Yes	❑ No		
Does the EP's spouse or significant other work?				❑ Yes	❑ No	❑ N/A	
If so, what is his/her income?							
Does the EP receive other financial support?				❑ Yes	❑ No	❑ N/A	
(including, but not limited to, governmental assistance, child support, or alimony)							
Does the Employee Partner have children? (if so, how many and what are their ages?)							
Does Employee Partner have insurance? (check all that apply)							
❑ Home	Deductible:			❑ Health	Deductible:		
❑ Auto	Deductible:			❑ Renters	Deductible:		
Please DETAIL the Employee Partner issue. (Include dates and times, if possible.)							
What is the Employee Partner's major need for assistance?							
Did the Employee Partner and/or immediate family need to go to the hospital?				❑ Yes ❑ No	If yes, for how long?		
Has the Employee Partner missed work? If so, how many days?				❑ Yes ❑ No	If yes, for how long?		
How long will the EP be unable to work?							
Did the Employee Partner or family member die?				❑ Yes ❑ No	If yes, what are the funeral costs?		

Please itemize the Employee Partner's monthly expenses.					
Rent/Mortgage		**Cell Phone**		**Groceries**	
Car		**Electricity**		**Student Loans**	
Car Insurance		**Gas (for heat)**		**Credit Cards**	
Gas (for car)		**Water**		**Other (please explain)**	
Phone		**Cable/Satellite**			

Amount of assistance requested? (required)	

If requesting assistance due to a funeral or medical expenses, please submit the funeral bill and/or medical invoices (with vendor contact information) when submitting this request.

Disclaimer: The above information will be used by those involved with the Employee Partners Care Foundation for the limited purpose of this request and will be shared with the appropriate personnel for evaluation. The information will be retained at the corporate office but will not be maintained in the Employee Partner's personnel file. The Employee Partners Care Foundation will not discriminate based on race, color, religion, sex, and national origin.

______________________________ ______________________

Employee Partner's Signature **Date**

______________________________ ______________________

General Manager's Signature **Date**

Fax # 972-888-7534 **Date Received _____/______/______**