HCA HOPE FUND

Hope Fund Application for Assistance

The Hope Fund helps employees who have been affected by hardship due to an eligible event beyond their control. This includes disasters, extended illness/injury and other special situations such as domestic violence. The fund offers assistance to help pay for essential living expenses, such as housing, utilities, food, clothing and other basic necessities.

Who's Eligible

Only eligible HCA employees may receive assistance through the Hope Fund, based on set criteria. To be eligible for assistance from the fund, you must meet all requirements:

1) You must be employed by an HCA affiliate as a regular full-time or part-time employee or PRN working a minimum average of 12 hours per week at the time of the event causing the hardship, as well as when assistance is provided.
2) You cannot have received financial assistance from the Hope Fund within the past 12 months.
3) Your situation must meet the fund guidelines and meet the definition of emergency or hardship resulting from extended illness/injury, disaster or other situation (such as domestic violence) that is beyond your control. For the purposes of the Hope Fund, an emergency is defined as "an unexpected event or catastrophe that is nonrecurring or an unavoidable situation of a serious and urgent nature."
4) The event causing the hardship must have occurred in the past 12 months.

Dependent Guidelines

Only HCA employees can apply for assistance from the fund. When reviewing your application, your number of eligible dependents will be considered. Eligible dependents include your:

- Spouse (unless legally separated)
- Unmarried dependent children under age 19
- Unmarried dependent children under age 25 if dependent on you for support **and** a full-time student (as defined by the educational institution)
- Domestic partner (domestic partners must be non-relatives, of the same sex, over age 18 and share a residence)

What's Eligible

These situations meet the Hope Fund guidelines:

- Applicant or spouse/domestic partner has missed more than one week of unpaid time due to illness/injury (for self or for dependent family member)
- Applicant or dependent family member requires treatment with non-routine medical expenses (e.g., required out-of-network treatment, long-distance travel to receive treatment)
- Cost of medical treatment is preventing an applicant or dependent family member from receiving care
- Applicant or dependent family member has incurred extreme medical costs and the household income is 200% below poverty level
- Disaster such as fire, flood, tornado or hurricane
- Domestic violence
- Death in the immediate family causing financial hardship. Immediate family includes the employee's legal dependents, parent or legal guardian and stepparent.
- Death or terminal illness in immediate family requiring long-distance travel. Funding will only be provided once, for either travel to help care for terminally ill family member OR travel for funeral. Immediate family includes the employee's parent or legal guardian, stepparent, brother, sister, current spouse/domestic partner, children, stepchildren, grandparents, grandchildren, current mother-in-law and current father-in-law.
- Death of an employee

What's Not Eligible

- The Hope Fund does not provide assistance when the situation is the result of poor financial management.
- The fund will not provide assistance while you are receiving Workers' Compensation benefits.
- Costs related to divorce or separation, including costs related to child support or non-receipt of child support
- Costs related to bankruptcy
- Routine expenses (e.g., car repairs, home maintenance, child care)
- Hardship resulting from taxes, job loss, loss of overtime or low census

How the Process Works

- You must complete the entire application based on your situation.
- You **must** attach required documentation that will help the Grant Leader (typically your HR Director) and the Hope Fund staff better understand and verify your situation, as indicated below.
- Once you have submitted your application and documentation to your facility's Human Resources (HR) department, the Grant Leader will assign a case number to your application to ensure strict confidentiality. Only the Grant Leader and the Hope Fund staff will know your personal information.
- The local Hope Fund committee will review your application without any identifying information and will make a recommendation to the Hope Fund staff at HCA's home office in Nashville.
- The goal of the Hope Fund staff is to respond within five business days after receiving your application, including all required documentation, from your local facility. Your Grant Leader will let you know if your application is approved or denied.
- If approved, the Hope Fund staff will typically provide assistance via direct deposit into your account (as listed on page 5 of your application) or a check made out to you. In some situations, a check may be issued directly to a creditor.
- If your application is denied, you will receive a formal letter explaining the reason for the denial.

Supporting Documentation Requirements

The following documentation must accompany your application in order to be considered for assistance:

- Disaster — Provide copies of fire or insurance reports.
- Illness/injury — Provide physician documentation that identifies the type of illness or injury and the length of time that the individual is unable to work.
  - For out-of-the ordinary medical costs, please include a physician statement that shows the cost required to receive treatment and medical necessity.
  - For consideration of medical expenses, provide a physician statement of medical necessity, bills for treatment and household income.
- Domestic violence — Include a copy of an active restraining order.
- Death — Include individual's name and relationship to applicant, as well as the name, city and state of the funeral home.

Maximum Amounts at a Glance

Illness/injury: $1,500
Burial assistance: $1,000
Other: $1,000
Per rolling calendar year: 1 grant

Long-distance funeral travel: $1,000
Disaster: $2,500 (based on family size, household income and level of damage)
Per lifetime: $5,000 (excluding disaster)

If you have questions, contact the Hope Fund staff at (877) 857-HOPE or HopeFund@HCAHealthcare.com.

The term "HCA" refers to HCA Inc. and its affiliates. References to "HCA employees" refer to employees or affiliates of HCA Inc. All hospitals and facilities referred to in this application are owned by affiliates of HCA Inc.

SECTION A: TO BE COMPLETED BY LOCAL GRANT LEADER

Applicant Case Number
(Process Level and EIN) ______ - ______

SECTION B: APPLICANT GENERAL INFORMATION (*Please fill out and print this form.*)

Attention, Applicant: Your name, Employee Identification Number (EIN), address, phone number, position/title and dependent information will NOT be revealed to the local committee. The local committee will only identify your information by the case number assigned above, as this page will not be included in the committee's review packet.

Facility Name | City | State

Applicant's Name | Applicant's EIN (found on pay stub)

Applicant's Permanent Address (No P.O. Box) | City | State | ZIP Code

Applicant's Temporary Address, If Different From Above (No P.O. Box) | City | State | ZIP Code

Applicant's Phone Number

Applicant's Position/Title:

Applicant Employment Status: FT PT PRN ______ Hours per week
(In order to qualify, PRNs must average 12 hours per week.)

Length of Employment: ______ Years ______ Months

Marital Status: Single Married Domestic Partner Separated Divorced Widowed

Dependent Information: (*See definition of eligible dependents on instruction sheet.*)

Dependent Name	Age	Relationship	Full-Time Student?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Besides eligible dependents, do any other individuals depend on the applicant for financial support? Yes No

If yes, please briefly describe.

Has the applicant received assistance from the Hope Fund in the past 12 months? Yes No

Applicant Case Number

  -

SECTION C: NATURE OF APPLICATION

Reason for Application: Disaster Extended Illness/Injury Death Domestic Violence Other

Describe what has happened to the applicant. Include any information that would help us assess this situation.

What is the expected length of the applicant's hardship?

Which basic living expenses does the applicant need assistance with?

Housing Clothing Food Other:

Is the applicant currently working with community/government resources? Yes No

Describe the applicant's immediate needs. Please tell us anything that would help us assess this situation.

Applicant Case Number

-

SECTION D: MONTHLY FINANCIAL INFORMATION (*Please complete to the best of your ability.*)

Household Income/Assistance

Monthly **Income**

Applicant's take-home pay (excluding overtime)	
Spouse/partner wages	
Self-employment/2nd job	
Interest/dividends	
Rental income	
Retirement/pension/401(k)	
Social Security/SSI	
Workers' Compensation/disability	
Other household income	
Other	
Total Income	

Monthly **Assistance**

Refugee assistance	
Housing assistance	
Utility assistance	
TANF	
Food stamps	
Child/spousal support	
Unemployment insurance benefits	
Other	
Total Assistance	

Total Savings/Liquid Assets	
PTO Balance (hours)	
EIB Balance (hours)	

Expenses

Monthly **Housing Expenses**

Rent/mortgage	
Electricity	
Gas	
Phone	
Water	
Other	
Total Housing Expenses	

Other *Monthly* **Expenses**

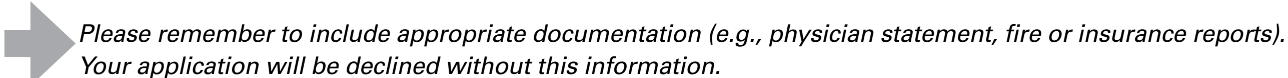
Food	
Car payment(s)	
Car insurance	
Child care/school tuition	
Medical costs that insurance doesn't cover	
Loans/credit card payments	
Pager/cell phone	
Cable/satellite TV	
Tuition, books, fees	
Other	
Total Other Expenses	

Total Expenses	

If your application is approved, the grant is typically provided directly to you via direct deposit into your bank account. Copies of utility bills are not necessary or required. Please provide the following information:

Bank Routing Number (9 digits): ______ Account Number: ______ Checking Savings

Name on Account: ______ Bank Name: ______



Please remember to include appropriate documentation (e.g., physician statement, fire or insurance reports). Your application will be declined without this information.

Your signature certifies that the information provided in this application is true and complete and authorizes the Hope Fund to obtain and/or verify all information necessary to process this application.

Applicant:

Name (*Please Print*): ______ Signature: ______ Date: ______

By signing or typing my name here, I certify that the information in this application is complete and true.

Applicant Case Number -

SECTION E: ILLNESS/INJURY *(Complete if applying for assistance based on illness/injury.)*

What is the medical condition/diagnosis of the person?

Yes No **Does the applicant have financial responsibility for the affected person?**

Yes No **Is the affected person covered by medical or dental insurance?**

Yes No **Does the affected person have any medical bills that are not covered by insurance?**

If so, how much do the bills total? $

Yes No **If the illness/injury is work-related, is the affected person currently receiving Workers' Compensation benefits?**

Yes No **Has the applicant or eligible dependent missed work (unpaid) because of this situation?**

SECTION E: DISASTER (*Complete if applying for assistance based on disaster.*)

Levels of financial assistance are based on household income, family size and extent of damage.

What type of disaster has affected the applicant?

Fire Tornado Flood Hurricane Earthquake Other:

What was the date of the disaster?

Where did the applicant live immediately following the disaster?

At home In hotel With family Other

What was the length of time displaced from home?

Where is the applicant currently living?

Did the applicant have a loss of food due to damage, power outage or displacement from home? (*Note: Funding is provided for those at income more than 200% below poverty level.*) Yes No

If applicable, how many family members had articles of clothing damaged or destroyed?

Was the applicant's home:

Owned Rented No housing expenses (*e.g., lived with a friend or family member*)

If the applicant had homeowners/renters insurance, will the insurance policy cover this type of situation?

Yes No No insurance

What is the applicant's insurance deductible? $

Describe the extent of damage to the applicant's home, content loss, primary means of transportation, etc.