CoxHealth Foundation

Application for Cox Family Assistance Fund

To apply you must complete the following:

- ☐ **Read the policy** and confirm that your request qualifies. This fund does **NOT** cover daily living expenses-rent, utilities, car, gas, etc. Your request must be for out of your control type crisis not related to everyday living expenses.
- ☐ Complete the application if your request qualifies.
- ☐ Have your supervisor send an email confirming employment, to: lisa.alexander@coxhealth.com
- ☐ Write an explanation of your need. The more details you can provide the better idea the employee committee has of the type of need they are trying to support.
- ☐ Send completed application, last paystub if relevant, and explanation of need to:

CoxHealth Foundation
3525 S. National, Suite 204
Springfield, MO 65807
Fax: 417-269-9599
Lisa.alexander@coxhealth.com

Questions?

Call 417-269-7150

Monday – Friday from 8:30 AM – 5:00 PM

www.coxhealthfoundation.com

Note: Applications are reviewed as received.

APPLICANT INFORMATION		
Employee Name:		Date of Birth:
Current Address:		
City:	State:	ZIP:
Email:		
Spouse's Name:		
Number of Children Living at Home:	Ages of Children:	

EMPLOYMENT/INCOME INFORMATION		
Department:	Location:	Supervisor Name/Number:
Date of Hire:	☐ Full Time	☐ Part Time

Monthly Gross Income:$	Social Security: $	Unemployment: $	
Alimony: $	Child Support: $	Other Income: $	
Spouse's Employer:	Spouse's Monthly Gross Income: $		
INSURANCE COVERAGE			
Medical Insurance: Yes No	Medicaid: Yes No	Medicare: Yes No	
FINANCIAL ASSETS			
Name of Bank:			
Amount in Checking:$	Amount in Savings: $	CD's / Stock's / Bond's: $	
REAL ESTATE			
Do You Own Your Home? Yes No	Finance Company:		
Balance Owed: $	Market Value: $	Monthly Payment: $	
Do You Own Rental Property? Yes No	If Yes, Monthly Income: $		
Do You Own Acreage? Yes No	If Yes, Monthly Payment: $		
PERSONAL PROPERTY			
Automobile Year:	Make:	Model:	
Automobile Year:	Make:	Model:	
Truck Year:	Make:	Model:	
Recreational Vehicle Year:	Make:	Model:	
Boat Year:	Make:	Model:	
Farm Machinery Year:	Make:	Model:	
Livestock: Yes No	If Yes, List:		
MONTHLY EXPENSES			
Rent/Mort: $	Utilities: $	Propane: $	Mobile Phone: $
Food: $	Gasoline: $	Medical Insurance: $	Auto Insurance: $
Child Support: $	Alimony: $	Other: $	Other: $
Loan (type/finance company):	Amount: $		
Credit Card:	Amount: $		
OUTSTANDING MEDICAL EXPENSES			
	Amount: $		
	Amount: $		

Please give an accounting of your circumstances that have resulted in this application.

If your request is related to daily living needs, we are sorry but the fund is unable to support these kinds of needs. The fund is designed to support those "out of your control" issues like a house fire, tornado, major medical, loss of spouse, etc. Please call the CoxHealth Foundation to clarify your need qualifies under the donor guidelines at 417-269-7150.

Thank you for your understanding of the purpose of this fund to provide for our employees in situations where there is typically no other resource for support.

If you receive assistance, can we tell your story to encourage future donor support? We will NOT use your name or any other personal information such as an address, financial details, etc.

☐ **Yes!** You are welcome to use my story, contact me. ☐ **No.** Please keep my story private.

I verify that the information contained on this application is correct to the best of my knowledge and that I can provide proof of any information stated on this application if requested.

Applicant Signature	Date	Phone