Application for Cox Family Assistance Fund

Made possible by employee donors to the CoxHealth Foundation

Questions or need help completing this application?
Call (417) 269-7150 or email chf@coxhealth.com
Monday – Friday from 8:30 AM – 5:00 PM

NOTE: Your request must be for a crisis out of your control and not related to everyday living expenses. This fund does **not** cover daily living expenses (i.e. rent, utilities, gas, etc.)

Application Instructions:

1. Read the policy (available at www.coxhealthfoundation.com). At the end of this application you will attest that you agree to the terms of this program.

2. Ask your supervisor to send an email confirming your employment status to chf@coxhealth.com.

3. Complete the application below – **including a detailed explanation of your need**. The employee committee reviewing your application needs as much detail as possible to ensure they are able to understand your situation and the need for which you are requesting assistance.

4. Gather required supporting documentation, including your last paystub and W-9.

After your application is complete,

send your completed application along with your last paystub and W-9 to:

Mail:
CoxHealth Foundation
3525 S. National, Suite 204
Springfield, MO 65807
Call 417-269-7150

Email:
chf@coxhealth.com

Fax:
(417) 269-9599

NOTE: Applications are reviewed as they are received.

Please print legibly to prevent delays in processing your application.

APPLICANT INFORMATION		
Employee Name:		Date of Birth:
Current Address:		
City:	State:	ZIP:
Email:		
Spouse's Name:		
Number of Adults Living at Home:	Number of Children (Under 18) Living at Home:	
EMPLOYMENT/INCOME INFORMATION		
Department:	Employee Number:	
Supervisor Name:	Supervisor Phone #:	
Supervisor sent confirmation of employment: ☐ Yes ☐ No	☐ Full Time ☐ Part Time	
Household Monthly Gross Income: $	Social Security: $	Alimony: $
Child Support: $	Other Income: $	
INSURANCE COVERAGE		
Medical Insurance: ☐ Yes ☐ No	Medicaid: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No
FINANCIAL ASSETS		
Name of Bank:		
Amount in Checking: $	Savings: $	CDs, Stocks, Bonds: $
REAL ESTATE		
Do You Own Your Home? ☐ Yes ☐ No		
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		
Vehicle Year:	Make:	Model:
Vehicle 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(s) (type/finance company):			Amount: $
Credit Card(s):			Amount: $
OUTSTANDING MEDICAL EXPENSES			
			Amount: $
			Amount: $

PLEASE CONTINUE TO NEXT PAGE TO PROVIDE REQUIRED DESCRIPTION OF YOUR NEED

Tell us your story. How can we help you? What is your specific need or request? Why are you requesting assistance? What circumstances should we consider when reviewing your application?
Be as specific as possible – attach additional pages if necessary.

NOTE: Your request must be for a crisis out of your control and not related to everyday living expenses. This fund does not cover daily living expenses (i.e. rent, utilities, gas, etc.) Thank you for your understanding; the purpose of this fund is to provide for our employees in situations where there are typically no other resources for support.

Please call the CoxHealth Foundation to clarify your need qualifies under the donor guidelines at 417-269-7150.

If you receive assistance, can we tell your story to encourage future donor support?
NOTE: We will NOT use your 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.

By signing, I acknowledge I have fully read and understood the policy. My request qualifies for this program under the policy.

Applicant Signature	**Date**	**Phone**