Spirit of Charity Foundation

H.E.A.R.T Fund

Helping Employees with Assistance in Rough Times

Confidential request for assistance
The Employee Assistance Fund Committee will review the request, and if approved, limit funding to a maximum of $500 per request per calendar year.

Date_____ Submitted by_____ Employee ID number_____

Assistance for (if different than submitted by)_____

Name_____
Last First Middle initial

Mailing address_____

City_____ State_____ Zip _____

Home phone_____ Cell phone_____ Work phone_____

Number of years employed at University Medical Center New Orleans or affiliate_____

Department_____

Have you ever received assistance from the Employee Assistance Fund in the past?_____

If yes, approximately how long ago?_____

Please give a detailed explanation of what sudden and unexpected conditions beyond your control led to your immediate need for assistance: _____

_____

_____

_____

_____

_____

What amount of assistance are you requesting up to $500? $_____

Please attach all statement(s) and bill(s) that support your request.

Do not write in this box. For Employee Assistance Fund Committee Members only.

O Approved Date_____ Amount approved $_____

O Not approved Reason_____

O Notification to employee Date_____ By_____

Submit completed form to
socfoundation@lcmchealth.org

University Medical Center New Orleans
LCMC Health

24-19574-111224