West Jefferson Hospital Foundation

Employee Assistance Fund

Confidential request for assistance
Please review the Employee Assistance Fund policy in the HR Policy Manual. 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 4 Digit 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 West Jefferson Medical Center 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 why you are requesting 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____

West Jefferson
Medical Center
LCMC Health

19-3410-0819