COVERMYMEDS EMERGENCY ASSISTANCE PROGRAM APPLICATION

CoverMyMeds Emergency Assistance Program is administered by Gifts of Kindness, LLC on behalf of The Columbus Foundation to help ensure funds are distributed efficiently, equitably, and with discretion. The Columbus Foundation staff will handle the day-to-day administration and grant-making decisions as they relate to this program. CoverMyMeds will not be involved with those decisions. All applications are kept in strict confidence and are considered on the basis of need and eligibility.

Documentation of your hardship event and expenses are REQUIRED. Please be prepared to share documents, such as but not limited to, paystubs, mortgage statements, utility bills, car loan statements, medical excuses or leave of absence documentation.

COMPLETE THIS FORM AND SEND TO:

- **MAIL: COVERMYMEDS EAP**
  C/O THE COLUMBUS FOUNDATION,
  1234 E BROAD ST, COLUMBUS, OH 43205
- **EMAIL: CoverMyMeds@columbusfoundation.org**
- **FAX: 614-251-4010 (ATTN: CoverMyMeds EAP)**

_____ _____

EMPLOYEE FIRST AND LAST NAME EMPLOYEE ID NUMBER

_____

HOME STREET ADDRESS

_____

HOME CITY HOME STATE HOME ZIP CODE

_____ (_____)_____

EMAIL PHONE

_____

JOB TITLE

IF APPLICABLE TO GUIDELINES

Have you been an employee with CoverMyMeds LLC for at least one year (since most recent hire date)?

☐ YES ☐ No

$_____

AMOUNT OF GRANT REQUESTED – ***MAXIMUM AMOUNT IS $3,000; MINIMUM AMOUNT IS $250***

ELIGIBLE HARDSHIP EVENTS
(PLEASE CIRCLE ONE; SEE GUIDELINES FOR ELIGIBLE FAMILY MEMBER AND DEPENDENTS LISTS)

Acts of Nature/Government declared disaster	Government-declared natural disaster	Fire	Terrorist or military action disaster
Any event determined by the Secretary of the Treasury to be a catastrophic nature	Domestic/Physical Abuse	Crime Victim (Violent or Non-violent)	Short-term illness or other short term medical, dental vision or hearing condition
Accident (unless caused by the associate's or applicable family member's negligence, recklessness, or intent)	Death of an associate, spouse/partner or dependent	Spouse/partner loss of job/income (temporary)	Loss of child support
Military deployment			

Please answer the following questions regarding your situation. Please note: Documentation of your hardship and expenses is REQUIRED.

1 Please provide a description of your emergency that led to your request for help. Use additional pages if necessary. You will be required to document the event. Examples include Doctor's excuses, police or fire reports, news stories, professional estimates, letters from landlords or social workers.

2 Please describe the needs that have resulted from the event. Use additional pages if necessary. Attach supporting documentation, such as paystubs, mortgage/rent statements, utilities, medical bills, etc.

I attest that the information provided above is true to the best of my knowledge and that the grant for which I am applying will be used for needs that are not met by any other source for assistance. Further, I acknowledge that my receipt of the requested grant is dependent upon whether I am eligible for such grant and the availability of funds.

_____ _____

ASSOCIATE SIGNATURE DATE

All information shared in this application will remain strictly confidential. The Columbus Foundation will contact a CoverMyMeds Human Resources representative for the sole purpose of verifying employment. CoverMyMeds will receive confidential reports that share the fund's balance and number of associates served. These reports have no personal identifying information.