Employee Giving Referral Form

The Employee Giving Committee determines the best way to distribute the Employee Giving Funds. Our goal is to assist individuals and staff who are in **dire need** of financial assistance. Unexpected emergency situations will be considered. However, assistance will not be considered for requests that fall into typical life events and daily living. To be considered for assistance, staff must be employed with Shadowfax for a minimum of 6 months. You will be asked to submit 3 estimates on requests for repairs. Please keep in mind the above mentioned considerations while completing this form. PLEASE NOTE: You will only be considered for assistance one time a year with a lifetime cap of $5,000.00.

1. General Information:
   Name: Circle One: Staff Individual
   (If individual, please complete section 4 also.)
   Date Of Request:
   Phone Number:
   Do you currently contribute to the Employee Giving Fund? Yes or No
   How long have you been employed with Shadowfax?
   Have you previously received assistance from this fund? Yes or No
   Amount Requested:

2. Reason For Request:
   a. Is this request for an emergency situation? Yes or No
   b. Please explain the reason that you are requesting assistance. Be specific. If the request is greater than $100, please include 3 estimates.

3. What steps have you taken to supplement your income?
   a. Have you worked additional hours at Shadowfax? Yes or No
   b. Have you obtained part time employment? Yes or No
   c. Have you requested assistance from any other source? (i.e. – Child Care Consultants, SSI, Medical Assistance, Salvation Army, Church, Healthy Network, Electric Co., Gas Co., family, friends, etc.) Yes or No (Please explain.)

   d. Please list any other avenues you have accessed for assistance.

4. (This section is for individuals only.)
   a. Do you reside in a Shadowfax CLA? Yes or No
   b. Who is your contact person?
   c. Have they been notified of your need? Yes or No
   d. Please check with fiscal to see how much the person has in your account prior to submitting this form.

Submitted By _____ Date _____

(This section will be completed by the Employee Giving Committee.)

If this employee has received previous financial assistance, complete this section.
Date of Assistance:
Reason For Assistance:
Amount Given:

Current Fund Balance:

Approved by:
Committee Member Signature/Date:

Not Approved by:
Committee Member Signature/Date:

_____ _____

_____ _____

_____ _____

_____ _____

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_____ _____

The following recommendations will be made to the employee:

1. Use our EAP program through Mazzitti and Sullivan.
2. Contact York Healthy Network.
3. Sign up for our Budgeting Class. If a class is currently scheduled, it will be listed on the staff portal.