



EMPLOYEE GRANT APPLICATION FOR ASSISTANCE

The Yellow and Black Giving Back Foundation (the “Foundation” or “Fund”) was established to foster our PHI community by supporting employees who are experiencing hardship. The Board of Directors and Distribution Committee serve as stewards for the fund to ensure that the grants awarded meet the mission, criteria and guidelines of the foundation.

Please review the grant application information and instructions before completing this application. If while completing this application you have any questions, please call the Foundation Coordinator at (602) 224-3501.

Section A: Applicant General Information

(PLEASE PRINT or WRITE CLEARLY)

Attention Applicant: Your name, employee number, address, phone number, position/title, and dependent information from page 1 will NOT be revealed to the Distribution Committee. The Committee will receive your information with a random case number and this page will not be included in the committee’s review packet.

Employee Name:		Employee Number:
Employee Permanent Address (<i>No PO Box</i>):		
City:	State:	Zip Code:
Employee Temporary Address, if applicable (<i>No PO Box</i>):		
City:	State:	Zip Code:
Employee Email Address:		
Employee Home Phone:	Employee Cell Phone:	
If the application is approved, where should the Foundation Coordinator mail the check?	<input type="checkbox"/> Permanent Address	<input type="checkbox"/> Temporary Address

Dependent Information (<i>See definition of eligible dependents in the Grant Application Information and Instructions Document.</i>)		
Dependent Name	Age	Relationship to Employee

FOUNDATION ASSIGNED CASE NUMBER: _____

Section A: Applicant General Information (For Committee Review)

Previous assistance. In the past, *have you applied for and/or received financial assistance from* the Foundation, or any other similar program administered by PHI?

Yes No If yes, date: _____ Name of program: _____ Amount received: \$ _____

What is the dollar amount needed to assist with the hardship? \$ _____

Employee Base/Department/Location Name: _____

Base/Department/Location City: _____

Base/Department/Location State: _____

Employee Position/Title: _____

Length of Employment with PHI: _____

Years: _____

Months: _____

Employment Status: _____

Full Time

Part Time 1

Part Time 2

Beside eligible dependents, do any other individuals depend on your for financial support? _____

Yes No

If yes, please briefly describe: _____

Employee Annual Salary: \$ _____

Total Annual Household Income: \$ _____

Estimated Monthly Household Living Expenses: \$ _____

Section B: Nature of the Application

Attention Applicant: Depending on your situation, you may be asked to complete an additional section and provide more detailed information specific to your situation.

Reason for application: _____

Natural disaster (*fire, flood, hurricane, tornado or earthquake*)

Critical illness or serious injury

Other qualifying emergency or crisis situation

Date event or situation occurred: _____

Provide a brief description of the situation. Include any information that will help in assessing this application.

Which basic immediate living expenses do you need assistance with? Select all that apply below.

Housing

Clothing

Food

Other (*please describe*): _____

FOUNDATION ASSIGNED CASE NUMBER: _____

Type of Hardship: Please check the ONE box that applies to your event.

<input type="checkbox"/>	<p>Natural Disaster</p> <p>The Foundation can help employees who are unable to pay for housing, food, clothing, and other basic living essentials because a natural disaster such as a fire, flood, tornado, hurricane, or earthquake has damaged or destroyed their primary residence. Levels of financial assistance are based on household size, extent of damage, and past levels of emergency assistance by relief organizations.</p> <p>Required Documentation: Fire, incident, or insurance reports, repair estimates, or any other documents that support the application should be submitted when available. Please include proof of insurance. Photos may be requested in certain situations.</p>
<input type="checkbox"/>	<p>Medical (Extended Illness/Injury)</p> <p>Mark this section only if you have been affected by an <i>extended illness or injury</i>. The Foundation can help employees who have an extended illness or an injury to themselves or within their immediate family, which requires absence from work and/or excessive medical costs resulting in a critical economic hardship. The Foundation does not reimburse for medical bills or premiums, but does help pay for essential living expenses such as rent/mortgage, utilities, and food when a medical condition has resulted in a loss of income. All sources of income, including Worker’s Compensation and/or Disability payments will be considered during the review process.</p> <p>Required Documentation: Physician documentation that identifies the type of illness or injury and the length of time the individual is unable to work. Please include copies of overdue living expenses that are a direct result of this event.</p>
<input type="checkbox"/>	<p>Other</p> <p>Mark this section only if you have experienced a critical emergency hardship <i>other than</i> a disaster or extended illness/injury, as defined in the sections above.</p> <p>The Foundation can help applicants who are unable to afford housing, utilities, food, clothing, and other basic living expenses because of catastrophic or extreme circumstances beyond the applicant’s control. These may include violent domestic abuse or other situations the applicant could not avoid or prevent. Funeral expenses related to the death of immediate family members (mother, father, children, spouse) will be considered if long-distance travel is required and/or it creates a financial hardship. Grants for travel expenses related to attending the funeral of an immediate family member will be for the employee only. Applications involving theft are not generally funded, but will be reviewed on a case-by-case basis.</p> <p>Required Documentation: Please provide copies of active restraining order, police reports, insurance reports, and deceased information, as applicable to your specific situation.</p>

Supplemental Form, Financial

Monthly Household Income

Applicant's take-home pay (<i>excluding overtime</i>)	\$	per month
Spouse's / partner's take-home pay	\$	per month
Other household income (<i>from adult children, roommate, etc.</i>)	\$	per month
Self-employment / second job take-home pay	\$	per month
Interest / dividends	\$	per month
Rental income	\$	per month
Retirement / pension / 401(k)	\$	per month
Social Security / SSI	\$	per month
Worker's Compensation / Disability	\$	per month
Other	\$	per month
Total Monthly Income	\$	per month

Monthly Expenses

Rent / mortgage	\$	per month
Electricity	\$	per month
Gas	\$	per month
Water	\$	per month
Food	\$	per month
Car payment(s)	\$	per month
Car insurance	\$	per month
Child care / school tuition	\$	per month
Medical costs that insurance doesn't cover	\$	per month
Loans / credit card payments	\$	per month
Home phone / cell phone	\$	per month
Cable / satellite TV	\$	per month
Tuition, books, fees	\$	per month
Other	\$	per month
Total Monthly Expenses	\$	per month

Liquid Assets / Vacation / Paid Time Off (PTO) Balance

Total savings / liquid assets / cash on hand	\$	
Vacation / PTO balance		Hours

Additional financial information may be requested for verification of expenses and financial hardship

FOUNDATION ASSIGNED CASE NUMBER: _____

Other Avenues of Support. Employees experiencing hardship are also encouraged to consider other avenues of support such as PTO, 401(k) loans or hardship withdrawals, Employee Assistance Program (EAP), as well as any government and/or local community programs. Please list all other efforts you have put forth to alleviate your financial hardship.

Employee Applicant Declaration and Agreement

Signature and Attestation

I understand that no employee is entitled to receive a grant, either by their employment, their history of contributions to the Foundation or because of any precedent inferred from a previous grant from the Foundation. I understand further that this application will be treated in a confidential manner by the Foundation; however, information will be reported to PHI Group, Inc., on a periodic basis.

Employees are expected to provide truthful and accurate information. In its due diligence, if the Foundation discovers any information in this application to be materially untrue or fraudulent, I recognize that I may no longer expect this application to be treated confidentially and also recognize that information provided herein may be reported to PHI Group, Inc.

My signature below certifies that the information provided is true and complete, authorizes the Foundation to obtain and/or verify all information necessary to process this application, and releases PHI Group, Inc., and the Foundation from any liability associated with the rejection of or funding of this application. In addition, I hereby agree to provide any requested documentation supporting the information provided.

Employee Applicant Signature:	
Date:	

I understand that the Foundation would like to share stories of our employees who received a grant to encourage others to ask for help, and to demonstrate the Foundation’s mission being fulfilled. My signing below authorizes the Yellow and Black Giving Back Foundation to share in publications, marketing materials, or their website, the reason(s) for awarding a grant to me, not by name. I understand that any information shared about my situation will not contain details that identify me.

Employee Applicant Signature:	
Date:	

Please send the signed application and available documentation to Yellow and Black Giving Back Foundation via email at PHIFund@YellowandBlackGivingBack.org

Section C: Human Resources or Payroll Department Only

The Human Resources Department will review the application information with the employee and with payroll to ensure all the information provided to the Distribution Committee is up to date.

Applicant Information (to be completed by Human Resources or Payroll only)	
Annual Salary (before taxes):	\$
Average paycheck amount (biweekly, before taxes):	\$
Average paycheck amount (biweekly, after taxes):	\$
Has any income been lost due to this hardship?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, how much?	\$
Is the applicant currently out on a leave of absence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what was the starting date:	
If yes, what is the anticipated end date:	
Does applicant have remaining hours available to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vacation / PTO:	
Sick / Extended Medical Leave:	
Does applicant contribute to the 401(k) plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, has applicant applied for a 401(k) loan?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, has the 401(k) loan been granted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does applicant have disability insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, has a disability claim been filed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what is the benefit amount?	\$
Is applicant currently receiving Worker's Compensation Benefits?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other information not included above, but relevant for the review of the grant:	

Please provide any additional information that you feel is relevant and important in understanding the applicant's situation and supporting the financial need and hardship resulting from the situation.

FOUNDATION ASSIGNED CASE NUMBER: _____

Human Resources Declaration

To the best of my knowledge, based on the review of this application, our employee qualifies for Grant Assistance.

HR Representative Name:

HR Representative Signature:

Phone Number:

Distribution Committee Decision

Approval Date:

Denial Date:

Comments: