

The Community Foundation of Middle Tennessee
The Delek Employee Care Fund

APPLICATION FOR ASSISTANCE

Applicant Name (please print clearly): _____

Current Mailing Address: _____

** Approval notification is sent to you by mail so please provide a valid mailing address **

City: _____ State _____ Zip: _____ County/Parish: _____

Daytime Phone: (____) _____ Is it okay to leave you a message? YES NO

Other Phone: (____) _____ Is it okay to leave you a message? YES NO

Email Address: _____ Is it okay to contact you by email? YES NO

Date of Hire: _____ **Delek location where employed:** _____

Help completing this form is available! Email EmergencyGrants@cfmt.org or call 615-321-4939 with questions.

SECTION A: WILL YOU QUALIFY?

An employee can only be approved for assistance once within a 12-month period. The maximum grant amount available for assistance is \$2,500. The maximum award is not guaranteed. **All payments are made directly to vendors as bill payments; no assistance funds will be sent directly to applicants.**

To qualify for this program and receive assistance you must meet all of these requirements:

- You must be currently employed by Delek and have been employed for at least 90 days.
- You must be regularly scheduled to work 20 or more hours per week.
- The qualifying incident must have happened within the past 60 days.
- Your situation MUST fall into one these four categories: (check the one below that describes your situation)

Natural Disaster: For situations such as a wildfire, flood, tornado, hurricane, severe storms, or other weather that have damaged or destroyed the employee's primary residence or essential property. The Fund cannot pay to repair other property such as fencing, carports, garages, or storage buildings, and cannot pay to replace non-essential items, such as electronics or furnishings. Photographs, insurance reports, or other documentation is required.

Life-Threatening or Serious Illness or Injury: For the employee, partner and eligible dependents. Applicants do not automatically qualify for a grant when they, or their dependents, are diagnosed with or suffer a life-threatening or serious illness or injury. There must be resulting significant financial impact. **Not qualified:** Healthy pregnancies, injuries occurring more than 60 days ago, routine dental treatments, and any elective procedures. Medical documentation will be required.

Death Incident: This includes the death of the employee, spouse or eligible dependent(s). The loss of income, cost of burial or funeral expenses, or resulting medical bills prevents an employee from affording basic living expenses. The Fund cannot pay for travel to funerals, caskets, grave markers or other funeral and burial expenses. **Assistance will be provided in other ways to offset these costs.** Copy of the death certificate, obituary, or other documentation along with proof of financial impact (such as receipts) will be required.

Catastrophic or Extreme Circumstances: This includes damage by fire, major home damage that could not be prevented, crime against the employee (robbery, arson, assault, extreme vandalism), or another reportable incident beyond the applicant's control. **Not qualified:** routine home repairs, damages due to negligence, vehicle maintenance or registration, high utility bills, lawful wage garnishment, bankruptcy, court ordered child support payments, reduced hours or pay, taxes, typical job layoffs, typical divorce or separation, or roommate vacancy. Documentation of the incident will be required.

SECTION C: DESCRIBE YOUR SITUATION

Which qualifying situation caused the economic hardship? (Read the descriptions above. Circle the **one** that fits best.)

Natural Disaster Life-Threatening Illness or Injury Death Incident Catastrophic or Extreme Circumstances

Name of Incident: _____ Date of Incident: _____
(example: tornado, fire, flood, type of injury, name of illness, theft, domestic abuse) **(must be within past 60 days)**

How many people live in your household? Number of Adults _____ Number of Children _____

The Delek Employee Care Fund

Describe what happened: _____

Estimate the financial impact of the incident: How much has this cost you? _____

Please tell us anything else that would help us understand the hardship you or your family are experiencing. **If this application is being completed by someone other than the employee (as in the case of death or other inability to complete the form), please explain and provide a contact name and information.** _____

SECTION D: ASSISTANCE GRANTS

Grants are only to help pay for limited types of essential living expenses, which are:

- Rent, mortgage or other housing payments
- Temporary housing and security deposits for new housing
- Essential utility bills (electricity, heat, water)
- Medical expenses related to the incident and not covered by insurance
- Minor home repairs needed to maintain home safety and livability

Grants cannot be made to pay for other, non-essential expenses do not request payment for these things, such as:

- Insurance premiums or deductibles
- Cable, phone or internet service
- Car payments, repairs or car insurance
- Furniture, appliances, electronics
- Funeral expenses or grave markers
- Legal fees, legal fines or court costs

If your request is approved, payments will be made on your behalf to the vendor(s) you list. **All grants are made directly to vendors as bill payments; no assistance funds will be sent directly to you, and no reimbursements can be made.**

Provide the name of the vendor to be paid, the complete address, the account number or identifying information, amount due, and due date. Although the maximum grant amount is \$2,500, smaller sums are often awarded, so list the vendors in order of priority. **For each vendor, attach appropriate documentation (bills, lease, mortgage coupon, statement, etc.).**

NOTE : We cannot make payments without clear, complete information including full account numbers or other payment information, addresses and documentation. Omitting this information or copies of your bills will delay your application significantly.

Vendor/Biller Name	
Complete Mailing Address for Payment	
Payment Amount & Due Date	
Account Number or Identifying Information	

Vendor/Biller Name	
Complete Mailing Address for Payment	
Payment Amount & Due Date	
Account Number or Identifying Information	

Vendor/Biller Name	
Complete Mailing Address for Payment	
Payment Amount & Due Date	
Account Number or Identifying Information	

SECTION E: DECLARATIONS AND AGREEMENT

No employee is entitled to receive a grant, either by their employment, their history of contributions to the Fund or because of any precedent inferred from a previous grant from the Fund. Grants will not be made before an employee has demonstrated an immediate financial need and provided all required documentation.

This application will be treated in a confidential manner by The Community Foundation of Middle Tennessee; however non-identifying statistical information will be reported to Delek on a periodic basis.

Employees are expected to provide truthful and accurate information. In its due diligence, if The Foundation discovers any information to be untrue, it shall have the right to unilaterally waive its confidentiality and report its findings to the Company. The fiduciary expectations of all Delek employees are paramount and a breach of these standards will be reported to Delek.

Your signature below certifies that the information provided is true and complete, authorizes The Community Foundation to obtain and/or verify all information necessary to process this application, and releases Delek and The Community Foundation of Middle Tennessee from any liability associated with the rejection of or funding of this application. Remember that the maximum amount any employee or family member can receive in a 12-month period is \$2,500. The maximum amount is not guaranteed, and in some cases, lesser amounts will be awarded.

I agree to provide the requested documentation supporting my application and acknowledge that no request can be approved without complete documentation of the qualifying incident.

I understand that if the Foundation finds any information I have provided to be untrue or falsified, all findings will be reported to my employer.

Applicant's Signature: _____ **Date:** _____

SUBMITTING YOUR APPLICATION

Submit your completed and signed application with requested documentation in one of these ways:

- **EMAIL:** Scan all pages and email to EmergencyGrants@cfmt.org with Delek Employee Care and your name in the subject line.
- **FAX:** Fax single-sided pages of your application and documents to **615-327-2746**. Do not fax photographs; you can submit photographs separately by email or by mail if needed.
- **MAIL:** Make copies of everything you send to us, and mail your application and documents to:

The Delek Employee Care Fund of The Community Foundation of Middle Tennessee
3833 Cleghorn Avenue, Suite 400, Nashville, TN 37215 (phone) 615-321-4939 (fax) 615-327-2746