# APPLICATION FOR
# BAYHEALTH EMPLOYEE ASSISTANCE FUND FORM
**(TO RECEIVE ASSISTANCE)**

**NOTE: This Page is CONFIDENTIAL**

**PART I – To be completed by employee requesting assistance from the Bayhealth Employee Assistance Fund**

| | | | |
|---|---|---|---|
| Name (Last, First, MI) | | Employee # | Date of Hire |
| Mailing Address (Street, City, State, Zip) | | | |
| Department/Facility | Work Telephone # | Home Telephone # | Cell Telephone # |
| Have you had assistance from the Bayhealth Chaplaincy Fund/Bayhealth Employee Assistance Fund in the past?<br>❒ Yes ■ No | | | |

Describe short-term financial need and attach supporting documentation, e.g., utility shut-off notice, eviction/foreclosure notice, funeral expense:

_____

_____

_____

_____

I understand that I may not receive assistance from the Fund more than once in a 12-month period or more than twice in a 36-month period.

_____ _____

Employee Signature Date

**PART II – To be completed by Vice President, Human Resources or Designee (Bayhealth Employee Assistance Fund Bank Only)**

I hereby certify that I have reviewed this application and hereby approve/disapprove _____ for the receipt and use of Bayhealth Employee Assistance Fund.

_____ _____

Signature/Vice President of HR/Designee Date

**RETURN THIS FORM TO HUMAN RESOURCES**