PSEG

Employee Crisis Fund

Criteria for Funding and Application

The PSEG Employee Crisis Fund provides short-term, emergency support to employees or eligible dependents that are experiencing a financial hardship resulting from a sudden, severe, overwhelming and unexpected event that is beyond their control. The event results in significant pressure on the family's financial resources. The Community Foundation of New Jersey administers the PSEG Employee Crisis Fund and in its sole discretion determines incident eligibility and award amount. The Community Foundation staff is available to assist all applicants in this process. Call 973.267.5533 extension 3002 with questions.

Eligibility

Those eligible for consideration of a grant from the Employee Crisis fund are:

- PSEG active, regular full-time employees who are **not** an officer level or above.
- PSEG active, regular part-time employees
- In the case of death of the employee, then the spouse or eligible dependents may apply.
    - Immediate family member is an employee's child, spouse, domestic partner, civil union partner, parent or any other relative who is a member of the employee's household.
    - Please note, a child is defined as a biological, adopted or foster child, a stepchild, a legal ward or a child of a person standing in place of the parent. A parent is defined as a biological parent, a parent-in-law, or a legal guardian.
- An employee can apply for each incident only once even if it is on-going.

Grants: The maximum grant amount available for assistance is $5,000. The maximum award is not guaranteed, and in some cases, a lesser amount will be awarded. All payments are made directly to vendors as bill payments; *assistance funds are not sent directly to applicants.*

Request Criteria

To qualify for this program and receive assistance you must meet certain requirements:

1. You must meet the PSEG Employee Assistance Fund employment requirements outlined above.
2. You must be experiencing financial hardship due to the unexpected nature of the qualifying incident.
3. The qualifying incident must have happened within the past 90 days.
4. Your situation **MUST** fall into one of the following four categories:

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Natural Disaster: Situations such as a wildfire, flood, tornado, hurricane, severe storms or earthquake that have damaged or destroyed the employee's **primary** residence. The Fund cannot pay to repair other property and cannot pay to replace non-essential items, e.g. electronics, etc. Photographs and/or insurance reports may be required.

Catastrophic Illness or Injury: The Fund is not a substitute for medical insurance; employees 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 financial need placing significant pressure on the family's financial resources. Doctor confirmation and/or medical documentation will be required.

Death Incident: This includes the death of the employee, spouse, or eligible dependent(s). The loss of income or the cost of funeral expenses or medical bills must significantly impact the family's resources. The Fund may also be able to pay expenses to bring a child whose parents have died to live with a new family, typically a relative. The Fund cannot pay for travel to funerals, caskets, grave markers or other funeral expenses.

Catastrophic or Extreme Circumstances: This includes but is not limited to: fire, major home damage that could not be prevented, serious crime against the employee (robbery, arson, assault, domestic abuse or another reportable crime) that significantly impacts the family's resources. Police, fire, or other official incident report may be required.

Assistance grants do not include reduced work hours or pay (lost compensation due to missed time from work); expenses associated with divorce settlements or child custody cases; items covered by insurance, insurance co-pays, premium or deductibles; credit card bills; home foreclosure; car repair; accumulated financial distress; accidental damages due to negligence; legal fees.

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APPLICATION FOR ASSISTANCE

General Information:

Name: _____

First Last

If this application is being completed by someone other than the employee such as supervisor or manager (as in the case of death), please explain and provide both your contact information as well as the contact information of the family member.

Permanent (Primary) Address:

Street: _____

City, State, ZIP _____

County: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Preferred Email: _____

Department: _____

Job Title: _____

Work Site: _____

Employee Number: _____

Marital Status:

_____ Single _____ Married _____ Divorced/Separated _____ Domestic Partner

If, because of the catastrophe, you cannot receive mail at your home, provide current address and/or alternate mailing address from above. Approval notification is sent to you by mail, so please provide a valid mailing address.

Street: _____

City, State, ZIP _____

Employee Name:_____

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Family Members (Spouse and Dependents Only)	Relationship	Age

Rent or own? Please circle one Rent Own

Number of Adults in Household: _____ Number of Children in Household _____

What is your annual family income including all wage earners: $_____

Referral Source:

_____ Company Intranet
_____ Co-Worker
_____ Human Resources
_____ Employee Communication/Publication
_____ Manager
_____ Other Referral Source

Which qualifying situation caused the financial hardship? Check the category below that best fits your situation.

_____ Natural Disaster
_____ Catastrophic Illness or Injury - *(SEE ATTACHMENT A OF APPLICATION)*
_____ Death Incident
_____ Catastrophic or Extreme Circumstances

Name of Incident: _____

(Example: tornado, fire, flood, type of injury, name of illness)

Date of Incident **(MUST BE WITHIN PAST 60 DAYS)**: _____

Amount Requested: $_____

Have you applied before to the PSEG Employee Crisis Fund for assistance (please circle)? Y N
If yes, date applied (mm/dd/yy): _____

Who has been affected by the situation? _____

Is the affected person covered by medical or disability insurance?(Please circle) Y N
Have they applied for disability benefits? (Please circle) Y N

Employee Name:_____

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If your **primary** home was damaged, will insurance cover part of the cost? (Please circle) Y N
Your deductible amount? _____

Describe what happened to cause your financial hardship:

_____
_____
_____
_____

Describe in detail your immediate needs.

_____
_____
_____
_____
_____

How will this grant help you recover from the immediate financial crisis?

_____
_____
_____
_____
_____
_____

Please tell us anything else that would help in understanding the circumstances of the hardship you or your family is experiencing

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Employee Name:_____

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Important to Note: If application is for a Catastrophic Illness or Injury, doctor confirmation and/or medical documentation will be required. <u>Please see Attachment A.</u>

If applying for Catastrophic Illness, please provide the Healthcare Provider's, name, address, and telephone number:

Last Name: _____
First Name: _____
Street: _____
City, State, ZIP _____
Telephone Number _____

Have other resources been considered or used, such as the American Red Cross, Salvation Army, or other similar social service agencies. Please comment on efforts and response.

Assistance Sought	**Results**	**Date**	**Amount**
Homeowner's or Renters Insurance			$
Auto Insurance			$
Medical Insurance			$
Social Service Organization, e.g., Red Cross, United Way, Crisis Assistance, Salvation Army			$
FEMA			$
Your Religious Community			$
Family Members			$
Loan Program			$
Other			$

If the application is approved, the Community Foundation of New Jersey will make the grant(s) in the form of a check(s) payable to the vendor(s) and the applicant will be notified of the payment(s) by mail. All grants are made directly to vendors as bill payments; assistance funds are not sent directly to applicants.

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Employee Name:_____

Provide the name of the vendor, the complete address, the account numbers (when relevant), amount due, and due date. Please list the vendors in order of priority. For each vendor, attach appropriate documentation (bills, lease, mortgage coupon, statement, etc.)

Vendor Name	
Vendor Address	
Basic Need Covered	
Payment Amount and Due Date	
Account Number	

Vendor Name	
Vendor Address	
Basic Need Covered	
Payment Amount and Due Date	
Account Number	

A completed application must be submitted in order for the application to be reviewed. Incomplete applications will be held for 30 days after the application has been submitted awaiting the additional information required. After 30 days, the applicant will need to apply by resubmitting a new application and all supporting documents again. We cannot make payments without clear, complete information including full account numbers and all documentation. Omitting copies of your bills will delay your application.

Checklist

- Carefully read the requirements to see if you qualify.
- Submit a copy of most recent paystub or payment statement (to help verify employment)
- Signed Declarations and Agreement page
- Supporting documents are necessary for evaluating and determining the eligibility of the grant request. Examples include but are not limited to:
    - Vendor documentation (bills to be paid)
    - Mortgage Coupon or Statement/Lease
    - Lodging Receipts in the case of evacuation
    - Insurance Claim Forms
    - Medical Documentation if needed (See Attachment A) and Explanation of Benefits (EOB)
    - Police, Fire, or other official incident report if for Catastrophic Circumstances
- If death incident, please provide a copy of the Death Certificate or Obituary

Employee Name:_____

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Agreement and Authorization – Please Read Carefully
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 New Jersey however; non-identifying statistical information will be reported to PSEG on a periodic basis.

I certify that the information provided in this grant application and any attachments to it is true and correct as of the date set forth below. My signature acknowledges and permits the Community Foundation of New Jersey to verify all information including employment status. This includes making appropriate contacts and disclosures with my creditors, health care provider and others referenced in this application to ensure that reported information is accurate.

Signature Required: _____ **Date** _____

If you receive a grant, would you be willing to be contacted by a Community Foundation of New Jersey representative to share your story/experience? _____ Yes _____ No

Date Received	
Application Status	_____ Approved _____ Denied _____ Withdrew _____
Log #	

Mail or fax completed and signed application with requested documentation to:

The Community Foundation of New Jersey
Attention: PSEG Employee Crisis Fund
Post Office Box 338
Morristown, NJ 07963-0338
Phone: 973.267.5533
Fax: 973.267.2903

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ATTACHMENT A
TO BE COMPLETED BY HEALTH CARE PROVIDER
IF APPLYING FOR CATASTROPHIC ILLNESS OR INJURY

To the attending physician: The employee below has applied for crisis funding from the PSEG Employee Crisis Fund for his/her self and/or the patient named below. This form is required for your patient to be considered for a grant.

Name of PSEG Employee: _____

Name of Patient: _____

Patient Relationship to Employee: _____

Patient Address: _____

City, State, ZIP _____

Does the patient have a catastrophic illness or injury? Please circle. Y N

Note: Catastrophic illness or injury is defined as a serious illness, serious injury, impairment, or physical condition that a licensed physician certifies as critical, life threatening or terminal.

Date on which the patient's catastrophic illness commenced: _____

Probable duration of patient's catastrophic illness or injury: _____

Describe the catastrophic illness or injury using appropriate medical facts within your knowledge (attach supplemental sheets if necessary).

_____

_____

_____

_____

Does the patient need constant care? Please circle. Y N

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Employee Name: _____

If yes, what is the estimated amount of time that the patient will need this care?

_____

_____

_____

_____

Name and Address of Healthcare Provider of Healthcare Provider:

_____

_____

_____

_____

Telephone Number of Healthcare Provider: _____

Signature of Healthcare Provider: _____

Date: _____

Mail or fax completed and signed application to:

The Community Foundation of New Jersey
Attention: PSEG Employee Crisis Fund
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Morristown, NJ 07963-0338
Phone: 973.267.5533
Fax: 973.267.2903