Please fill out this application completely and submit to your administrator/director for signature approval and submission. You may go to www.noble-hc.com for more information on the Employee Emergency Fund policy and procedures. All information provided in this application will be kept confidential**.** Please Remember there is **MINIMUM 6 MONTH EMPLOYMENT REQUIRED TO APPLY**. Full-time and part-time positions are eligible. This form may be completed by a concerned coworker on behalf of an employee in need.

Questions? Please contact your Administrator, HR Manager or Department Manager.

Noble Healthcare - Employee Emergency Fund

Grant Application

Applicant Name: _____

Name of Person Submitting Application (if different from Applicant): _____

Facility / Location: _____

Current Position: _____

Are you: Full-Time OR Part-time

Current Wage/Salary: _____

What other options have you looked into to meet this need? (Loan from family/friends; vacation cash out, etc.)

_____

_____

Is there anyone else that contributes to your household income? (Spouse, partner, etc.) **Yes** / **No** If yes, amount $_____

How many children under 18 years old are in your household? _____

Amount Requested $_____ (Required) Have you ever applied for emergency funds in the past? **Yes** / **No**

Specify how you will use these funds: Medical Expenses: $_____ Rent: $_____ Food: $_____

Utilities: $_____ Funeral Expenses: $_____ Other: $_____(Please explain)_____

Describe your emergency need, in detail: (Attach additional pages, if needed) _____

_____

_____

_____

_____

Please scan and email this signed application to: joshw@noble-hc.com or text it to 208-371-3449

Applicant/Submitter Signature: _____ Date: _____

My signature above indicates that I have completed this application truthfully.

Administrator / Director Signature: _____ Date: _____

FOR OFFICE USE ONLY: