



# EMPLOYEE EMERGENCY ASSISTANCE FUND APPLICATION FOR ASSISTANCE

I am applying for:

\_\_\_ DESIGNATED RECIPIENT TRUST FUND  
(Donations are made to provide assistance to a particular employee.)

OR

\_\_\_ UN-DESIGNATED RECIPIENT TRUST FUND  
(Donations are made to a general fund to assist others as their needs are identified; limited to \$2,500)

Name: \_\_\_\_\_ Employee ID#: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Date Hired: \_\_\_\_\_ Bi-weekly Pay Rate: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Dept/Agency: \_\_\_\_\_ Job Title: \_\_\_\_\_

Dept/Agency HR Rep: \_\_\_\_\_ HR Rep's Phone: \_\_\_\_\_

Are you currently working? Yes  No  If no, last day worked: \_\_\_\_\_

Expected return to work date (if applicable): \_\_\_\_\_

Approximate dollar amount needed due to emergency: \$ \_\_\_\_\_

<i>Specified dollar amount from the fund to be used for the following:</i>		
<b>Payee</b>	<b>Remarks</b>	<b>Amount</b>

**EXPLAIN YOUR EMERGENCY/FINANCIAL HARDSHIP:**

(Please explain in detail the nature of the unexpected emergency and financial hardship. Include any major expenses that may have arisen due to the unforeseen circumstance. Attach additional pages, if necessary.)

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**PERSONAL FINANCIAL INFORMATION:**

**INCOME:** Applicant's Monthly Net Income: \_\_\_\_\_  
Other Monthly Income: \_\_\_\_\_  
Spouse's Monthly Net Income: \_\_\_\_\_  
**TOTAL MONTHLY NET INCOME:** \_\_\_\_\_

**EXPENSES:**

Mortgage/Rent \$ \_\_\_\_\_/month  
Food \$ \_\_\_\_\_/month  
Utilities \$ \_\_\_\_\_/month  
Car payment/Insurance \$ \_\_\_\_\_/month  
Medical Insurance/Copays \$ \_\_\_\_\_/month  
Loans/Credit Cards \$ \_\_\_\_\_/month  
Other \_\_\_\_\_ \$ \_\_\_\_\_/month

**TOTAL EXPENSES** \$ \_\_\_\_\_/month

**SAVINGS & INVESTMENTS:**

Cash Savings \$ \_\_\_\_\_  
401(k) \$ \_\_\_\_\_  
457 \$ \_\_\_\_\_  
Other \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL ASSETS** \$ \_\_\_\_\_

*Please attach documents verifying above information. Only Committee Members will be allowed to review this information.*

Please note that the Committee will evaluate and verify whether other financial resources have been utilized, including but not limited to savings, investments, annual leave/vacation buy-down options, 401(k) loans and/or hardship withdrawals, and disability benefits.

**DEPENDENTS (please list relationship and age):**

\_\_\_\_\_  
\_\_\_\_\_

**TAX EXEMPT DISCLAIMER:** As a condition of participating in this program, the County makes no representation or guarantees to either the contributor or the recipient with regard to the tax status of contributions made pursuant to the provision of this agreement. Persons making contributions to undesignated or designated recipients may likely not be able to take a charitable tax deduction and are advised to consult their own tax advisors. Likewise, recipients of assistance may be taxed on the amount received and are advised to consult their own tax advisors.

I hereby authorize the Ventura County Employee Emergency Assistance Fund Committee to verify any and all facts and statements.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Submit completed application to:**  
Ventura County Human Resources/Benefits  
800 S. Victoria Avenue, #1970  
Ventura, CA 93009-1970

Upon receipt of completed application, the Committee will meet within 14 calendar days to determine approval/disapproval. Please note however that failure to respond to all questions may result in a delay of processing.