EMPLOYEE EMERGENCY ASSISTANCE PROGRAM
APPLICATION FOR ASSISTANCE

I am applying for:

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

Donation Request Recipients: ☐ Dept/Agency Wide ☐ County Wide

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: $_____

Specified dollar amount from the fund to be used for the following:

Payee	Remarks	Amount

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.)

_____

_____

_____

_____

_____

_____

_____

_____

PERSONAL FINANCIAL INFORMATION:

INCOME: Applicant's Monthly Net Income: _____

Other Monthly Income: _____

Spouse's Monthly Net Income: _____

***TOTAL MONTHLY NET INCOME*:** _____

***EXPENSES*:**		***SAVINGS & INVESTMENTS:***	
Mortgage/Rent	**$_____/month**	**Cash Savings**	**$_____**
Food	**$_____/month**	**401(k)**	**$_____**
Utilities	**$_____/month**	**457**	**$_____**
Car payment/Insurance	**$_____/month**	**Other _____**	**$_____**
Medical Insurance/Copays	**$_____/month**		
Loans/Credit Cards	**$_____/month**		
Other _____	**$_____/month**		
TOTAL EXPENSES	**$_____/month**	***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 County of Ventura Employee Emergency Assistance Program Committee to verify any and all facts and statements.

_____ _____

Signature Date

Submit completed application one of three ways to:

Mail: County of Ventura HR/Benefits
800 S. Victoria Avenue, #1970
Ventura, CA 93009-1970

Email: EEAP.Info@ventura.org

Fax: (805) 654-2665

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.