AISD Disaster Relief Fund Application

Request for Disaster Relief Assistance Packet

AISD employees may request emergency financial assistance from the Austin ISD Disaster Relief Fund, once in a 12-month period, if they are in extreme financial need due to a **catastrophic emergency**. Many sadly face difficult hardships; but because of the limited monies available in the Fund, only those who have suffered severe financial hardship due to an unforeseen catastrophe or disaster are eligible.

Employees Eligible for Assistance

All current benefits-eligible employees. If several family members work for the District, only one will be eligible to receive emergency funding on behalf of the family.

Family member is defined as the employee's spouse, partner, children, or those family members for whom the employee is financially responsible.

Eligibility is determined without regard to race, color, religion, sex, national origin, age, disability, military status, or other protected class.

Expenses Qualifying as an Emergency Hardship resulting from a Catastrophic Disaster

Emergency hardships are considered any of the following which cause the employee severe financial hardship for which there is no other source of funding.

1. **Expenses due to catastrophic property losses not covered by insurance.** Funds needed to establish or re-establish a habitable and safe residence following (a) a natural disaster such as a hurricane, fire, flood, or tornado or (b) a criminal event such as arson or criminal mischief.

2. **Expenses due to a catastrophic medical emergency not covered by insurance**. Funds needed to pay bills not covered by insurance. A couple of examples of catastrophic medical emergencies include (a) spinal injury causing paralysis and (b) methicillin-resistant Staphylococcus aureus (MRSA) infection.

None of the above examples constitute automatic awarding of assistance from the Employee Disaster Relief Fund. Losses or expenses covered by insurance will not be considered appropriate for assistance from the Fund. If any monies are owed to the District or items required to be returned by the employee applicant, the request for assistance may be denied.

Applicants must verify they do not have access to other resources. To be considered, the application must be fully completed. **Incomplete applications will not be considered.**

Disaster Relief Assistance Application Form

The AISD Employee Disaster Relief Assistance Fund is a program offering one-time financial assistance to employees who have experienced a non-recurring, sudden or emergency-related financial hardship due to an **unforeseen or unavoidable event**.

The Fund is *not* designed to address ongoing financial challenges and is *not* a loan requiring reimbursement. The fund is not designed to cover expenses related to funeral of a non-AISD employee.

To be considered, this form must be *legible* and *fully* completed with all supporting documentation attached. Do not send original documents (e.g., police reports) because they will not be returned to you. Submit copies instead. Attach additional pages, if necessary, to fully answer each question.

Mail or hand-deliver to:

Employee Disaster Relief Fund
TO: EAP Coordinator
New HQ
4000 S IH 35 Frontage Road (8th Floor)
Austin, Texas 78704
(512) 414-2282

Employee Name: _____

Home Address: _____

Contact Phone #: _____ E-mail Address: _____

EID#: _____ Job Title: _____

Work Phone #: _____ Work Location: _____

PLEASE CHECK which applies to you (each is defined on page one)?

☐ Catastrophic property losses not covered by insurance—official documentation required
☐ Critical medical emergency not covered by insurance—official documentation required, plus authorization to release medical information (last page in this packet)

Please attach the required documentation supporting your claim (such as a police report, emergency room report, medical diagnosis, receipts, insurance papers, coverage denial letter, photographs, and other official reports or documentation which independently verify your claim of emergency hardship).

PLEASE CHECK all applicable:

☐ I have exhausted all other appropriate means of assistance.
☐ The hardship is unexpected and beyond my control.
☐ I understand that any monies I may be granted from this Fund are considered taxable income and, therefore, reported as such by AISD to the Internal Revenue Service.
☐ I understand that I am solely responsible for the validity of the information provided on this application and that the personal financial information is current and accurate. I understand that any intentional misrepresentation in this application may result in cancellation of any award; my having to repay any monies granted; and, may also result in adverse employment consequences for me.

_____ _____
Signature Date

Emergency Description (Please attach all documentation to this Application.)

1. Describe the emergency hardship.

2. How much money are you requesting from the Fund? (Maximum amount is $500.) _____
   NOTE: Because of federal taxes and withholding, any awarded amount will be less than $500.

3. For what purpose will the money be used?

4. Do you have funds to cover this immediate need (e.g., a savings or checking account)?

5. List the documentation you are providing which validates your claim of an emergency hardship as defined on page one.

Office Use Only File No._____

Date Received: _____ By: _____

Date Approved: _____ Amount: $_____

or Date Denied: _____ Reason: ☐Situation does not meet definition authorizing assistance through the EAFund ☐Insufficient monies in EAFund ☐Other

_____

_____

_____

Authorization to Release Medical Information
When Claiming Catastrophic Medical Emergency

HIPAA is the Health Insurance Portability and Accountability Act of 1996. The legislation is intended to assure the portability of health insurance, reduce health care fraud, guarantee the privacy and security of health information, and standardize health care industry transactions.

- ✓ I understand that this authorization is voluntary.
- ✓ I understand that my medical information may be protected by various Federal Rules, Regulations, and Laws.
- ✓ I authorize the sharing of my attached medical records only on a need to know basis by the Employee Assistance Coordinator and the Employee Disaster Relief Independent Selection Committee.
- ✓ I authorize the use of my attached medical records for the sole purpose of verifying and supporting my claim of a catastrophic medical emergency as set forth in this request for emergency assistance.
- ✓ I understand that failure to submit such medical records will limit the ISC's ability to determine if I qualify for a grant from the EAFund.

Printed Name: _____

Signature: _____

Date: _____

PLEASE MAINTAIN A COPY OF THIS DOCUMENT AND ANY ATTACHMENTS FOR YOUR RECORDS BECAUSE YOUR SUBMISSION WILL NOT BE RETURNED. THANK YOU.