Employee CareFund Program Application

Name_____ Date_____ Employee ID/Badge # _____

Address_____ City_____ State_____ Zip Code _____

Department_____ Current Position_____ Hire Date:_____

Job Status: ☐ FT ☐ PT Phone Number:

☐ PRN _____ (PRN worked minimum hours of 250 worked over last nine (9) months)

Reason for Employee CareFund Need:

(Supporting Documentation (for everything but groceries and gasoline) must be attached and included with this form for Employee CareFund Program Application to be considered)

☐ I have read and understand the policy for the Employee CareFund Program and certify I meet all eligibility requirements.

☐ I certify I have completed nine (9) consecutive months of service with Cheyenne Regional.

☐ I certify I have had no corrective actions within the last 12 months.

☐ I understand that Cheyenne Regional reserves the right to amend or terminate the offering of the Employee CareFund program, at any time.

☐ I understand the maximum benefit paid is $3,000 within three (3) years from the date of application.

☐ I understand that funds from the Employee CareFund Program pays approved expenses directly to the creditors (except for groceries or gasoline).

☐ I understand that this is not a contract of employment, and that all employment with Cheyenne Regional is voluntary and at-will, meaning that I or Cheyenne Regional have the right to terminate the employment relationship at any time, for any reason or no reason, and that this agreement does not alter that at-will employment relationship.

Please Sign and Date the form. Once complete, email the signed form to Benefits@crmcwy.org. Please allow four business days for HR processing after submission of form

Signed _____ Date _____

Stop Here

APPROVAL / DENIAL:

Has Employee had any corrective actions in the last 12 months? Y / N

Employee CareFund Program Committee _____ Date _____

Approved: _____ Denied & Reason _____