

**CARING CONNECTION PROGRAM**

**REQUEST FOR EMPLOYEE ASSISTANCE**

|  |  |  |
| --- | --- | --- |
| **BENEFICIARY INFORMATION** | | |
| **Name** |  | |
| **Contact Info**  *(Phone or Email)* |  | |
| **AU Department** |  | |
| **STATEMENT OF NEED** | | |
| **Description of Need**  *(While respecting privacy, please include sufficient information for proper review.)* | |  |
| **Number of Dependents**  *(As indicated on your tax filing)* | |  |
| **Type of Assistance Needed**  *(Place X in appropriate category)* | | [ ] **Financial** (Amount: $\_\_ )  [ ] **Household**  [ ] **Transportation**  [ ] **Other** (please describe): |
| **Date Needed** | |  |
| **Checks Made Payable To**  *(Landlord, Utility Company, Store)* | |  |
| **Intended Use of Assistance** | |  |
| **SUBMISSION INFORMATION** | | |
| **Name**  *(Person submitting the request\*)* | |  |
| **Signature**  *(Person submitting the request)* | |  |
| **Submission Date** | |  |

***\*****May be submitted by the beneficiary or by a fellow employee.*

***SUBMISSION****: Please return completed form to the Benefits Office or a Caring Connection Committee member.*

***FINANCIAL NOTE****: Payments will be issued from the Accounts Payable Office to the third party requested. Please understand that payments may not be made directly to an employee, and cash equivalents (gift cards) are not permitted.*