Magellan Health Employee Relief Fund Application

The Program: The Magellan Health Employee Relief Fund helps employees who are experiencing financial hardship due to a government declared disaster or other extreme situation by making grants available to help cover basic living needs. Other employees and your employer make these grants possible.

In addition to financial support from the Emergency Relief Fund, you may also be in need of support services provided by a Magellan Employee Assistance Program (EAP) provider via eMbrace for virtual, in-person or telehealth counseling. Also, refer to eMbrace for additional resources including legal and identify theft resolution and work/life resources and referrals services.

Eligibility: You or your surviving eligible family members, as defined by company handbook, are eligible to apply if you meet all the following conditions:

- You are a full or part time employee of Magellan Health.
- You have experienced financial hardship due to a qualifying event that happened within the past 90 days. Qualifying events that happen outside of the 90-day period with extenuating circumstances may also be considered. A qualifying event is:
  - A government declared natural disaster (flood, earthquake, wildfire, tornado, etc.) that has affected your primary residence.
  - A serious illness or injury (employee or eligible family member) that affects your ability to pay for basic living expenses.
  - A death (employee or eligible family member, as defined by the company's bereavement policy) when loss of income, funeral expenses, or medical expenses not covered by insurance affect your ability to cover basic living expenses.
  - Catastrophic or extreme circumstances (fire, robbery, assault, domestic abuse) that affect your ability to cover basic living expenses.

Reduction in Magellan employee hours is not an eligible event; however, reduction in spouse's hours may be eligible depending on circumstances.

Grants: To ensure we can provide assistance to as many Magellan employees as possible, grant support is limited to up to $1,000 annually per employee, with a career lifetime maximum of four applications.

Each application must be for a separate and unique qualifying event.

Grant checks from the St. Louis Community Foundation will be sent directly to a vendor to cover eligible expenses from a current bill or invoice. No distributions will be made directly to employees.

Application: To be considered for grant support, complete all four pages of the application and provide requested supporting documentation. Print your name at top of each page. Answering questions completely will help us process your request quickly. Please attach current bills, invoices, and other supporting documentation.

You will be notified of the status of your application at the email or address you provide below, generally within 10 business days of receipt.

SECTION 1: INFORMATION ABOUT YOU

Employee Name (print clearly):			
Permanent Home Address:			
City:		State:	Zip:
Daytime phone: ( )	Other phone:	Email you check regularly, work or home:	

Employees, printed clearly: _____

	( )	
		Have you applied to this program before? ☐Yes ☐No
Hire Date:	Job Title:	

SECTION 2: DESCRIBE YOUR SITUATION

Which qualifying incident caused your current financial hardship?

☐**Natural Disaster** ☐**Serious Illness or Injury** ☐**Death in Family** ☐**Catastrophic or Extreme Circumstances**

Detail of incident:_____ Date of incident: _____
(tornado, flood, type of illness or surgery, deceased's name & relationship, name of circumstance, etc.) (must be within 90 days of application)

Was the incident covered by insurance? ☐Yes ☐No

If yes, is your application today being submitted after insurance coverage has been applied? ☐Yes ☐No

If no, why not?

Describe what happened that caused your financial hardship:

Please tell us anything else you feel would help us understand the hardship you and your family are experiencing as a result of this incident:

Have social service agency resources been requested or used? If you have already received services, please tell us which organization(s), how they were able to help, and include details of monetary or other support:

Employees, printed clearly: _____

SECTION 3: SPECIFIC REQUEST

Grants are paid to vendors in response to an unpaid bill or invoice for eligible, basic expenses. Examples of eligible expenses include:

- rent, mortgage or other housing payments
- temporary housing and security deposits for new housing
- utility bills (electricity, heating, water, etc.)
- medical expenses not covered by insurance
- home repairs necessary to restore or maintain safety
- funeral expenses for immediate family, as defined by company bereavement policy
- car repair or payments
- internet, phone payments
- furniture, appliances, electronics (only after fire, flood or natural disaster)
- cleaning services (only after fire, flood, or natural disaster)

The Program **cannot** make grants for the following:

- reimbursements to employee or other individual
- legal fees
- credit card debt
- collection agency requests
- student loans or expenses
- home repairs due to negligence or neglect

Grant Payment: If an application is approved, payment(s) to the vendor(s) will be made by check and will include the employee's account number, if applicable, and a copy of the bill or invoice provided with the application. In general, the minimum vendor payment is $250; the annual maximum is $1,000.

Grant Documentation: Please list the bills you need assistance with, ***listing the most important ones first***. If you are requesting payments to more than three vendors, attach a page with identical information provided. Please include the following:

- Confirmation of your qualifying event, for example:
  - Published obituary or death certificate for death
  - Note from doctor, leave of absence paperwork, for medical bill for injury or illness
  - Fire, police, or other official reports for catastrophic events
- Bill, invoice, lease, mortgage coupon, statement of amount due.
  - Approved travel costs may be paid directly to credit card company with appropriate documentation (receipts and credit card statement showing same amounts); applicants cannot be reimbursed.

Vendor Name	
Vendor Mailing Address	
City, State, Zip	Invoice/Bill due date:
Your account number	Payment amount:

Vendor Name	
Vendor Mailing Address	
City, State, Zip	Invoice/Bill due date:
Your account number	Payment amount:

Vendor Name	
Vendor Mailing Address	
City, State, Zip	Invoice/Bill due date:
Your account number	Payment amount:

Employees, printed clearly: _____

SECTION 4: THE FINE PRINT

This charitable program was established in 2023 by Magellan Health to receive gifts from employees, the company, and others who believe in the power of community members helping each other. The program is a charitable entity because of the company's partnership with the St. Louis Community Foundation, a 501(c)3 public charity whose mission is to help organizations, families and businesses put their charitable dollars to work in the community. The program is controlled and administered by the Community Foundation for the support of eligible employees who apply for support. Though Magellan Health and its leaders initiated the fund and advise the Community Foundation, all decisions are determined by the Community Foundation.

An application does not guarantee grant support. If awarded, the grant support you receive is not considered an employee benefit. Applications are assessed without regard to your work evaluation or position within the company and will not impact your employment in any way.

This application will be confidential between you and the Community Foundation.

Your signature below signifies that you understand the paragraphs above, that only one application for support can be filed in a calendar year, that the minimum vendor payment is $250, that the annual maximum that you can request is $1,000, and that support may be below this amount.

Your signature below also certifies that the information you provided is true and complete, releases the St. Louis Community Foundation and Magellan Health from any liability associated with the denial of or funding of this application, and authorizes the Community Foundation to verify information provided in connection with processing this application.

Signature: _____ Date: _____

Before you submit, complete the Application Checklist for your own peace of mind:

- ☐ I read the requirements and I feel that I qualify
- ☐ I emailed MHERF@stlgives.org or called 314-880-4957 with any questions I had
- ☐ I completed Sections 1, 2 and 3 with all the details requested
- ☐ I am enclosing current required documentation for each vendor listed in Section 3. If applicable, I also included documentation of the incident, such as an obituary, police, or fire report
- ☐ I read Section 4 thoroughly, and signed and dated my application
- ☐ I am keeping a copy of my application for my files
- ☐ I am emailing or mailing my entire application and supporting documentation to MHERF@stlgives.org

The **Magellan Health Employee Relief Fund,** a component fund of the St. Louis Community Foundation, a 501(c)(3) public charity, does not discriminate on the basis of race, religion, creed, national origin, gender, age, color, sexual orientation, veteran status, physical or mental disability. The St. Louis Community Foundation is solely responsible for all decisions regarding charitable distributions from the fund.

Send your completed, signed application with supporting documentation to MHERF@stlgives.org
Magellan Health Employee Relief Fund
#2 Oak Knoll Park
St. Louis, MO 63105