



Ports America Employee Crisis Fund

Criteria for Funding and Application

The Ports America Employee Crisis Fund provides short-term, emergency support for basic necessities to employees or eligible dependents who are experiencing a financial hardship resulting from a sudden, severe, overwhelming and unexpected event that is beyond their control. The event results in significant pressure on the family's financial resources. The Community Foundation of New Jersey administers the Ports America Employee Crisis Fund. Each application is reviewed on a case-by-case basis and, in its sole discretion, the Community Foundation of New Jersey determines incident eligibility and award amount. The Community Foundation staff is available to assist all applicants in this process. Call 973.267.5105 with questions.

Eligibility

Those eligible for consideration of a grant from the Employee Crisis fund are:

- Active, regular full-time employees of Ports America who are **not** an officer level or above.
- Active, regular part-time employees of Ports America
- In the case of death of an employee, then the spouse or eligible dependents who were living in the same household as the employee may apply.
 - Family member is an employee's spouse, child, civil union partner, parent or any other relative who is a member of the employee's household.
 - Please note, a child is defined as a biological, adopted or foster child, a stepchild, a legal ward or a child of a person standing in place of the parent. A parent is defined as a biological parent, a parent-in-law or a legal guardian.
- Eligible applicants may receive a maximum of one grant per incident even if it is ongoing, with a maximum of one grant for assistance per calendar year.

Grants: The maximum grant amount available for assistance is \$2,500. The maximum award is not guaranteed, and in some cases, a lesser amount will be awarded. All payments are made directly to vendors; *assistance funds are not sent directly to applicants*. In certain limited circumstances, an exception to this requirement may be made at the discretion of the Community Foundation of New Jersey.

Request Criteria

To qualify for consideration under this program and receive assistance you must meet certain requirements:

1. You must meet the Ports America Employee Crisis Fund employment requirements outlined above.
2. You must be experiencing financial hardship due to the unexpected nature of the qualifying incident.
3. The qualifying incident must have happened within the past 90 days.
4. Your situation **MUST** fall into one of the following four categories:

Natural Disaster: Situations such as a wildfire, flood, tornado, hurricane, severe storms or earthquake that have damaged or destroyed the employee's **primary** residence only. The Fund cannot pay to repair other property and cannot pay to replace non-essential items, e.g. electronics, etc. Photographs and/or insurance reports may be required.



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Catastrophic Illness or Injury: The Fund is not a substitute for medical insurance; employees do not automatically qualify for a grant when they, or their dependents, are diagnosed with or suffer a life-threatening or serious illness or injury. There must be resulting financial need placing significant pressure on the family's financial resources. Doctor confirmation and/or medical documentation will be required.

Death Incident: This includes the death of the employee, spouse, or eligible dependent(s). The loss of income or the cost of funeral expenses or medical bills must significantly impact the family's resources. The Fund may also be able to pay expenses to bring a child whose parents have died to live with a new family, typically a relative. The Fund cannot pay for travel to funerals, caskets, grave markers or other funeral expenses.

Catastrophic or Extreme Circumstances: This includes but is not limited to: fire, major home damage that could not be prevented, serious crime against the employee (robbery, arson, assault, domestic abuse or another reportable crime) that significantly impacts the family's resources. Police, fire, or other official incident report may be required.

Assistance grants do not include reduced work hours or pay (lost compensation due to missed time from work); legal fees; expenses associated with divorce settlements or child custody cases; items covered by insurance, insurance co-pays, premium or deductibles; credit card bills; home foreclosure; car repair; accumulated financial distress; accidental damages due to negligence.



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Application for Financial Assistance

Personal Information

Applicant Name: _____

Permanent (Primary) Address

Street: _____

City, State, ZIP: _____

County: _____

Home Phone: _____

Mobile Phone: _____

Preferred Email: _____

Department: _____

Work Location: _____

Job Title: _____

Employee ID Number: _____

Marital Status:

_____ Single _____ Married _____ Divorced/Separated _____ Domestic Partner

If because of the catastrophe, you cannot receive mail at your home, provide current address and/or alternate mailing address from above where correspondence can be sent.

Street: _____

City, State, ZIP: _____

Family Members who reside in your household (as defined under eligibility on page 1)

Name	Age	Relationship

Please indicate if you rent or own? _____ Rent _____ Own

What is your annual family income including all wage earners? \$ _____

Name of Employee: _____ Page 3 of 11

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Referral Source:

☐ Company Intranet
☐ Co-Worker
☐ Human Resources

☐ Employee Communication
☐ Manager
☐ Other Referral Source

Which qualifying situation caused the financial hardship? Check the category below that best fits your situation.

☐ Natural Disaster
☐ Catastrophic Illness or Injury
☐ Death Incident
☐ Catastrophic or Extreme Circumstances

Important to Note: If application is for catastrophic illness or injury, doctor confirmation and/or medical documentation will be required. Attachment A must be completed.

Name and Date of Incident: _____

Please note: Incident must have been within the past 90 days to qualify. Example, tornado, fire, flood, type of injury, name of illness.

Amount Requested: \$ _____

Have you applied before to the Ports America Employee Crisis Fund for assistance? ☐ Yes ☐ No

If yes, date applied (mm/dd/yyyy) _____

Who has been affected by the situation? _____

Is the affected person covered by medical or disability insurance? ☐ Yes ☐ No

If your primary home was damaged, will insurance cover part of the cost? ☐ Yes ☐ No

What is your insurance deductible amount? \$ _____



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Describe what happened to cause your financial hardship.

Describe in detail your immediate needs.

How will this grant help you recover from the immediate financial crisis?

Please tell us anything else that would help in understanding the circumstances of the hardship you and your family is experiencing.



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Current Financial Information:

Net Monthly income: Please indicate all sources of income.

Applicant	\$ _____
Spouse	\$ _____
Other Income	\$ _____
Total Net Monthly Income	\$ _____

Monthly Expenses: Please indicate our average monthly expenses for the following items:

Rent	
Mortgage	\$ _____
Food	\$ _____
Utilities	\$ _____
Property Taxes	\$ _____
Auto/Gas	\$ _____
Insurance (Home)	\$ _____
Insurance (Auto)	\$ _____
Insurance (Life)	\$ _____
Child Care	\$ _____
Other _____	\$ _____
Other _____	\$ _____
Other _____	\$ _____

IMPORTANT TO NOTE: If application is for a Catastrophic Illness or Injury, doctor confirmation and/or medical documentation will be required. Please see Attachment A.



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From what other sources have you requested financial assistance in the last year? Please include all organizations for which you have applied or received assistance and indicate the amount provided below.

Organization/Agency	Outcome (approved, declined, pending)	Amount Provided
Homeowners/Renters Insurance		
Auto Insurance		
Medical Insurance		
Social Service Organizations or Charities (Red Cross, United Way, etc.)		
Your Religious Community		
FEMA		
Family Members		
Loan Program		
Other		

If the application is approved, the Community Foundation of New Jersey will make the grant(s) in the form of a check(s) payable to the vendor(s) and the applicant will be notified of the payment(s) by mail. All grants are made directly to vendors as bill payments; assistance funds are not sent directly to applicants. In certain limited circumstances, an exception to this requirement may be made at the discretion of the Community Foundation of New Jersey. Grants are contingent upon the availability of funds at any given time.

Provide the name of the vendor, the complete address, the account numbers (when relevant), amount due, and due date. Please list the vendors **in order of priority**. For each vendor, attach appropriate documentation (bills, lease, mortgage coupon, statement, etc.)

Vendor Name	
Vendor Address	
Basic Need Covered	
Payment Amount and Due Date	
Account Number	

Vendor Name	
Vendor Address	
Basic Need Covered	
Payment Amount and Due Date	
Account Number	

A completed application must be submitted in order for the application to be reviewed. Incomplete applications will be held for 30 days after the application has been submitted awaiting the additional information required. After 30 days, the applicant



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will need to apply by resubmitting a new application and all supporting documents again. We cannot make payments without clear, complete information including full account numbers and all documentation. Omitting copies of your bills will delay your application.

Checklist

- Carefully read the requirements to see if you qualify.
- Submit a copy of most recent paystub or payment statement (employment verification)
- Signed Declarations and Agreement page
- Supporting documents are necessary for evaluating and determining the eligibility of the grant request. Examples include *but are not limited to:*
 - Vendor documentation (bills to be paid)
 - Mortgage Coupon or Statement/Lease
 - Lodging Receipts in the case of evacuation
 - Insurance Claim Forms; photographs may be requested.
 - Medical Documentation if needed (See Attachment A) and Explanation of Benefits (EOB)
 - Police, Fire, or other official incident report if for Catastrophic Circumstances
 - If death incident, please provide a copy of the Death Certificate or Obituary

Agreement and Authorization – Please Read Carefully

No employee is entitled to receive a grant, either by their employment, their history of contributions to the Fund or has demonstrated an immediate financial need and provided all required documentation. Grants are contingent upon the availability of funds at any given time.

This application will be treated in a confidential manner by the Community Foundation of New Jersey however; non-identifying statistical information will be reported to Ports America on a periodic basis.

I certify that the information provided in this grant application and any attachments to it is true and correct as of the date set forth below. My signature acknowledges and permits the Community Foundation of New Jersey to verify all information including employment status. This includes making appropriate contacts and disclosures with my creditors, health care provider and others referenced in this application to ensure that reported information is accurate.

Employee releases PASS and its parents, affiliates, and subsidiaries and their parents, affiliates and subsidiaries, and the Community Foundation of New Jersey from any liability arising out of or associated with the rejection of or funding of the application request. Neither PASS nor any of their respective parents, affiliates, and subsidiaries nor their parents, affiliates, and subsidiaries have any responsibility with respect to the management of the Crisis Fund (including determinations with respect to applications for grants or otherwise), any obligation to make additional gifts to the Crisis Fund, or otherwise provide any grants, gifts or funds in furtherance of the purpose of the Crisis Fund.

Employee Signature Required: _____

Date: _____



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If you receive a grant, would you be willing to be contacted by a Community Foundation of New Jersey representative to share your story/experience? ☐ Yes ☐ No

Date Received	
Application Status	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Withdrew <input type="checkbox"/>
Log #	

Mail or fax completed and signed application with requested documentation to:

The Community Foundation of New Jersey
Post Office Box 338, Morristown, NJ 07963-0338
Phone: 973.267.5105
Fax: 973.267.2903
fkrueger@cfnj.org



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ATTACHMENT A - TO BE COMPLETED BY HEALTHCARE PROVIDER IF APPLYING FOR CATASTROPHIC ILLNESS OR INJURY.

If applying for Catastrophic Illness, please provide the Healthcare Provider's, name, address, and telephone number:

First and Last Name of Healthcare Provider: _____

Address: _____

City, State, ZIP: _____

Telephone: _____

Email: _____

To the attending physician: The employee below has applied for crisis funding from the Ports America Employee Crisis Fund for his/her self and/or the patient named below. This form is required for your patient to be considered for a grant.

Name of Ports America Employee: _____

Name of Patient: _____

Patient Relationship to Employee: _____

Patient Address: _____

City, State, ZIP: _____

Does the patient have a catastrophic illness or injury? Please circle. Y N

Note: Catastrophic illness or injury is defined as a serious illness, serious injury, impairment, or physical condition that a licensed physician certifies as critical, life threatening or terminal.

Date on which the patient's catastrophic illness commenced: _____

Probable duration of patient's catastrophic illness or injury: _____



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Describe the catastrophic illness or injury using appropriate medical facts within your knowledge (attach supplemental sheets if necessary).

Does the patient need constant care? Please circle one. Y___ N___

If yes, what is the estimated amount of time that the patient will need this care?

Signature of Healthcare Provider: _____

Date: _____

Mail or fax completed and signed application to:

The Community Foundation of New Jersey
Attention: Ports America Employee Crisis Fund
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Morristown, NJ 07963-0338
Phone: 973.267.5105
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