UFCW Local 75 Foundation, Inc.

CORONAVIRUS EMERGENCY HARDSHIP FUND

Submit completed application and supporting documents to:

ufcwlocal75foundation@ufcw75.org 1-800-665-0075 7250 Poe Avenue, Suite 400, Dayton, OH 45414

MEMBER INFORMATION

First Name: ______________________ Last Name: ______________________

Home Address: ______________________ Cell: ______________________

______________________ Email: ______________________

______________________ Last 4 digits of SSN: ______________________

Employer: ______________________ **Total Payment Requested: $**______________________

HARDSHIP INFORMATION

- ☐ Loss of income due to COVID-19 diagnosis (must provide copy of doctor's diagnosis, recent paystub)
  Last day of work: ____________ Return to work date: ____________
- ☐ Loss of income due to health care provider recommended quarantine
  (must provide copy of doctor's quarantine recommendation, recent paystub)
  Last day of work: ____________ Return to work date: ____________
- ☐ Loss of income due to Employer-required quarantine (must provide recent paystub)
  Last day of work: ____________ Return to work date: ____________
- ☐ Loss of income associated with caring for a family member diagnosed with COVID-19
  (must provide copy of doctor's diagnosis, recent paystub)
  Family Member Relationship: ____________
  Last day of work: ____________ Return to work date: ____________
- ☐ Loss of income due to quarantine by government order (must provide recent paystub)
  Last day of work: ____________ Return to work date: ____________
- ☐ Additional childcare expenses related to COVID-19 from a certified provider
  (must provide copies of receipts before and during pandemic showing increased costs)

Explanation of Payment Requested (mandatory): ______________________

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OFFICE USE Committee Decision: ☐ Accept ☐ Deny Date of Decision: ____________
Check Number: ______________________ Check Amount: $ ____________

HIPAA PRIVACY AUTHORIZATION FORM
AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

UFCW Local 75 Foundation Inc. may need to investigate a short term disability or medical leave taken in relation to COVID-19 in order to verify your Coronavirus Emergency Hardship Fund payment.

I, ________________________________, hereby authorize the use or disclosure of my protected health
(write your name)

information as described below:

AUTHORIZATION

________________________________ is authorized to disclose the following protected health information
(write name of your health insurer)

to Joy Church and Amanda Jeakle of the United Food & Commercial Workers Union Local 75.

INFORMATION TO BE DISCLOSED

The health information that may be disclosed are the reason, duration, and other details of any short term disability, sick leave, or medical leave taken from March 23, 2020 to December 31, 2020.

PURPOSE OF DISCLOSURE

The purpose of this use or disclosure is pursuant to the verification of application for a UFCW Local 75 Foundation Inc. Coronavirus Emergency Hardship Fund payment.

EFFECTIVE PERIOD

This Authorization Form is valid beginning on __________________ and expires on December 31, 2020.
(write today's date)

ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) of facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature: ____ Date: ________________

Printed Name: ____

Printed In-House