HARRISHEALTH SYSTEM
P.O. Box 66769
Houston, Texas 77266-6769

EMPLOYEE DISASTER RELIEF APPLICATION

EMPLOYEE NAME: _____
EMPLOYEE ID: _____

DATE OF EVENT: _____

TYPE OF EVENT: (Check all that apply.)
- □ HURRICANE
- □ TORNADO
- □ FLOOD
- □ FIRE
- □ MAJOR MEDICAL EXPENSES
- □ BURIAL/FUNERAL EXPENSES
- □ OTHER TYPE OF PERSONAL DISASTER (Specify):

_____
_____
_____

PRIMARY RESIDENCE:
One (1) box for each type of coverage listed below must be marked in order to properly submit your claim.
- □ I DO NOT have Flood Insurance.
- □ I HAVE Flood Insurance, but cannot satisfy my deductible.
- □ I DO NOT have Windstorm Insurance.
- □ I HAVE Windstorm Insurance, but cannot satisfy my deductible.
- □ I DO NOT have Homeowner's Insurance.
- □ I HAVE Homeowners' Insurance, but cannot satisfy my deductible.
- □ I DO NOT have Renter's Insurance.
- □ I HAVE Renter's Insurance, but cannot satisfy my deductible.

Documentation required: (Proof of Ownership)
- A copy of your home purchase paperwork or
- A copy of your most recent property tax receipt or
- A copy of your rental agreement or
- A copy of the declaration page of all primary residence insurance policy(ies) and
- Pictures of your damaged property damage.

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BURIAL/FUNERAL EXPENSES:

Name of Deceased: _____

Date Deceased: _____ What is your relationship to the deceased person? _____

Is there a burial or funeral Insurance policy in place? □ Yes □ No
If yes, attach a copy of the policy.

To what extent are you liable for this expense? $_____ or _____%.

Documentation required:

- A copy of the burial or funeral policy.
- A copy of the itemized funeral bill on company letterhead.
- Copy of Death Certificate

ILLNESS OF EMPLOYEE/SPOUSE OR DEPENDENT CHILD:

Name of Ill person:_____

What is their relationship to you:_____

Is this person covered under medical insurance □ Yes □ No
If yes, attach a copy of the policy.

To what extent are you liable for this medical expense? $ _____or _____%.

Documentation required:
Medical itemized bills with date and type of service.
Explanation of Benefits (EOB)

EMERGENCY SERVICES:
Itemized receipts are needed for all emergency work performed to limit financial loss. Itemized receipts should include: Date service was rendered, type of service performed, as well as the name, address, and Tax I.D. of the medical provider.

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BENEFIT LIMIT:
MAXIMUM BENEFITS AVAILABLE UNDER THIS PROGRAM MAY NOT EXCEED $3,000 PER YEAR, SUBJECT TO AN INDIVIDUAL NEEDS ASSESSMENT BY THE DISEASTER RELIEF COMMITTEE AND FUNDING AVAILABILITY.

CLAIM AMOUNT:

- TOTAL ESTIMATED FINANCIAL LOSS AT TIME OF CLAIM:
  $_____
- TOTAL CLAIM AMOUNT OF THIS REQUEST:
  $_____
- BENEFIT AWARD:
  $_____

AWARD DATE: _____

ACKNOWLEDGEMENT:

I REPRESENT and ACKNOWLEDGE that:

(1) I have read and understand the provisions of the HCHD Employee Disaster Relief Policy (Policy 6.05).

(2) I understand that the effect of my claim may cause Disaster Relief benefits to be paid to me.

(3) I swear that I do not have the capability to pay the costs outlined within this claim.

(4) I swear that, at this time, I do not have the ability to obtain a commercial loan to cover the cost outlined within this claim.

(5) I swear that I am not currently eligible to take a Hardship or Emergency Withdrawal from one (1) or both of the HCHD Defined Contribution Plans (i.e. 401K or 457(b) Plans).

(6) I swear that I do not have financial assistance currently available to me from any other means.

(7) I swear that I have not and will not file for reimbursement of these same expenses under FEMA or any other local, state, or federal relief fund.

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(8) I swear that if my claim for Disaster Relief benefits is approved, I will utilize the funds in the manner for which the money was disbursed.

(9) I agree that falsification of any part of this claim or misuse of funds awarded is grounds for immediate termination as determined by the Human Resources Department.

CLAIMANT NAME (PRINTED)	CLAIMANT SIGNATURE
EMPLOYEE I.D. #:	DATE OF CLAIM:
DATE OF HIRE:	EMPLOYMENT CATEGORY:

THE STATE OF _____ §

COUNTY OF _____ §

On this the _____ day of _____, 20 _____, _____ appeared before me, a Notary Public, and acknowledged that all information contained within this document is true and correct. This person has read and understands the effect of signing this Disaster Relief Form and has voluntarily signed the form for the purpose herein expressed.

SUBSCRIBED AND SWORN TO before me on _____, 20 _____.

Notary Public in and for the State of _____.

MAIL OR FAX THIS FORM TO:

HARRIS COUNTY HOSPITAL DISTRICT
Jocelyn Harden, Workers' Compensation Coordinator
2525 Holly Hall, Ste. 100
Houston, TX 77054
(713)566-6243 FAX (713)566-6024