Atria Cares^{SM} Application for Assistance

PROGRAM GUIDELINES

Atria Cares, Inc. is a public, nonprofit 501(c)(3) organization that grants temporary/short-term financial assistance to qualifying employees of Atria Senior Living, Inc. and its U.S. subsidiaries and their immediate family members in times of sudden, unforeseen and often tragic events that have threatened the health and welfare of themselves or someone within their household.

By submitting a request for assistance, applicants expressly authorize Atria Cares to verify all information contained in the application.

The application must be completed in full and all required documentation, along with the application, should be submitted on the Atria Cares website at www.atriacares.com. Incomplete applications will delay the processing of your request for assistance or may cause your application to be denied.

The Atria Cares Committee meets weekly to review applications and determines qualifications and the amount of financial assistance to be awarded based on a nondiscriminatory and objective determination of need. The Committee considers the facts and circumstances presented and the applicant's substantiation of need, as well as other financial resources available to the applicant including insurance reimbursements and other assistance programs. The Committee's decision will be communicated to the applicant and the applicant's Executive Director/General Manager, Community Business Director/Office Manager, or Support Center supervisor.

The following are examples of events that may create a hardship that qualifies an employee for assistance:

- Loss or needs due to fire, flood, or other natural disaster
- Sudden and severe accident, illness, or injury
- An unexpected death in the family
- Falling victim to a crime
- Past-due essential utilities (water, gas, electric), rent, or mortgage
- Emergency medical and dental bills not covered by insurance

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The following are examples of items that may be considered for assistance when precipitated by one of the above noted events (or a similar event):

- Payments to provide emergency food, clothing and/or shelter following a disaster
- Expenses for the repair or damage to the applicant's principal residence due to a natural disaster or other unforeseen event
- Assistance with utility bills, automotive loans or repairs to prevent the loss of an applicant's primary transportation
- Payments for medical or dental bills not covered by insurance
- Payments necessary to prevent the eviction of the applicant from his/her principal residence or foreclosure on the mortgage on that residence

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GENERAL INFORMATION

Name ____ Position Title ______________________________________

Community Name ____

Provide a detailed explanation of the event causing the hardship and the nature of the need for financial assistance. Also provide your future plans for alleviating/eliminating your financial hardship (i.e., Employee Assistance Program, financial counseling, personal budget, secondary source of income, etc.).

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Date of event causing the hardship (required) ____

Amount of financial assistance requested (required) $_____________________________________

Check "yes" or "no" for each question.

______ YES ______ NO Is your request for short-term relief?

______ YES ______ NO Was the event causing the hardship sudden and unexpected?

______ YES ______ NO Are you covered by a medical plan?

______ YES ______ NO Do circumstances threaten you or an immediate family member's health and/or welfare?

______ YES ______ NO Have you fully utilized all emergency financial resources that you may have available to resolve your situation?

______ YES ______ NO Have you contacted, applied to or received assistance from any other organization for relief, such as: Red Cross, United Way, Salvation Army, FEMA or local churches, etc.?

If yes, please provide the amount of assistance received. $__________________

HOUSEHOLD & FINANCIAL INFORMATION

The following information is used for purposes of determining your financial need and the amount of assistance, if any, to be awarded. The failure to provide the requested information will delay the processing of your request for assistance.

Number of persons in household including yourself: ___________ Number over age 18: ___________

MONTHLY INCOME AND EXPENSES

List all that apply within your household

Income	Monthly Amount
Employee's take-home pay	$
Spouse or partner's take-home pay	
Additional earnings in the household	
Alimony	
Child support	
Social Security	
Short-/long-term disability	
Food stamps (value)	
Worker's compensation	
Unemployment benefits	
Other:	
(a) Total	**$**

Expenses	Monthly Amount	Late/Past Due Balance
Rent/mortgage	$	$
Homeowner's/renter's insurance		
Groceries		
Utilities (i.e. gas/electric/water/oil/trash)		
Phone (home & mobile)		
Auto loans: number of loans ______		
Credit cards: number of credit cards ______		
Cable/satellite television		
Internet		
Transportation		
Medical & dental (out-of-pocket costs)		
Alimony payment		
Child support payment		
Other:		
(b) Total	**$**	

Net Monthly (Shortage) Overage **(a) minus (b)=** **$**

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HOUSEHOLD & FINANCIAL INFORMATION (CONT.)

OTHER ASSETS

Please list all other assets/resources that you have available.

Description	Amount
Checking	$
Savings	
Retirement savings account (i.e. 401(k), IRA)	
Fair market value of home minus loan	
Other investments:	
Total	**$**

DETAILS OF REQUEST FOR FINANCIAL INFORMATION

List all bills, services, etc., for which you are seeking financial assistance.

Please attach copies of all bills and documents showing amount owed to your application.

Description	Amount
	$
Total	**$**

Insurance/Other Financial Assistance: List type and amount(s) that you have received or anticipate receiving associated with the reason for this request (i.e., gifts, insurance reimbursements, grants, fundraisers, etc.).

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Other Information (please provide any additional information that may be useful to the Committee in determining the need for financial assistance): ____

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EMPLOYEE ACKNOWLEDGEMENT

I attest that the information provided in this application is true and accurate. I also acknowledge that any amounts granted by Atria Cares will be used for the purposes described above. Any amounts that are subsequently reimbursed by insurance or other sources will be returned to Atria Cares.

Signature: ____ Date: ______________________

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TO BE COMPLETED BY THE EXECUTIVE DIRECTOR/GENERAL MANAGER, COMMUNITY BUSINESS DIRECTOR/OFFICE MANAGER, OR SUPPORT CENTER SUPERVISOR

Please provide details that verify the applicant's need for financial assistance. Your response should be in reference to the individual's need and circumstances, and not in reference to performance or tenure.

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Employee ID#_______________ Pay rate _______________ PTO balance _____________ DOH _____________

_______ Full-time _______ Part-time _______ On-call (check one)

_______ Exempt _______ Non-exempt (check one)

Signature: ____

Date: ____

ATRIA CARES COMMITTEE USE ONLY

Review Date:__________________ _______ Approved ______ Declined (check one)

Amount approved (if applicable) $___________________________

Notes: ____

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