San Luis Obispo County Employees' Association
1035 Walnut Street, San Luis Obispo, CA 93401
(805) 543-2021 • Fax (805) 543-4039 • Email: info@slocea.org

Members' Benefit Fund Guidelines

The purpose of this Fund is to provide financial assistance to members in times of an unforeseen personal crisis. The spirit behind the Members' Benefit Fund is to aid members who have exhausted all other options available to them and are still in need of one-time-only financial assistance. Any SLOCEA member may request financial assistance by completing a Members' Benefit Fund Request form and turning it in to the SLOCEA office. All information collected will be held in strict confidence. SLOCEA's General Manager shall have the authority to approve a request for funds up to $200.00. A request for funds between $200.00 and $750.00 requires approval by the Benefit Fund Committee (appointed by the Board of Directors). A request for more than $750.00 requires approval by the Executive Board of SLOCEA. Whenever possible, SLOCEA checks shall be payable directly to the source of emergency.

This is not a loan. There is no requirement to pay it back, but donations will be appreciated and accepted. Only one request per calendar year per member will be considered, and only one request per member each 36 months may be granted.

The Members' Benefit Fund Committee reserves the right to consider and award additional funds beyond the guidelines in the event of catastrophic circumstances. Catastrophic circumstances under the Members' Benefit Fund Guidelines are defined, but not limited to, fire, flood, catastrophic illness or injury, death of an immediate family member. Catastrophic illness or injury is an illness or injury which is expected to incapacitate the employee for an extended period of time and which creates a financial hardship because the employee has exhausted all of his/her accumulated leave. Catastrophic illness or injury is further defined as a debilitating illness or injury of an immediate family member that results in the employee being required to take time off from work for an extended period to care for the family member, when this creates a financial hardship because the employee has exhausted all of his/her accumulated leave. Immediate family shall mean son or daughter, including variation of step or foster, spouse, parents, grandparents, brother or sister of the employee, or corresponding relative by affinity.

If a member's request is denied, they may request, in writing, that the Committee reconsider their decision. The determination of the Members' Benefit Fund Committee is appealable to the full SLOCEA Board of Directors, whose decision is then final and binding on all parties. A Members' Benefit Fund appeal will be heard in a confidential closed session of a regular Board of Director's meeting.

SLOCEA retains the right to alter, amend, establish anew, or repeal the Members' Benefit Fund guidelines, and participation agreements at any time.

APPLICATION CRITERIA:

1. SLOCEA membership is required ***prior*** to the time of emergency.

Amended by Board of Directors September 15, 2010.

2. An immediate and unforeseen emergency must exist in order for the request to be approved.

3. All other options available to the member have been exhausted.

4. A Members Benefit Fund award must not have been granted to the SLOCEA member during the past 36 months.

5. A Benefit Fund request that is generated because of disciplinary action against the member will normally **not** be considered unless the discipline is unwarranted, and an appeal has been filed on the employee's behalf by SLOCEA.

6. Termination of county employment, whether voluntary or involuntary, is not considered a qualifying event for accessing the Members' Benefit Fund.

Amended by Board of Directors September 15, 2010.

MEMBERS' BENEFIT FUND APPLICATION

Please read the attached rules and criteria carefully to see if your situation falls under these guidelines. This application must be filled out completely. The more detail you provide, the easier it will be for the Committee to understand your emergency. This information will be held in the strictest confidence.

Name: _____ Date: _____

Address: _____ City/Zip: _____

Home Phone: _____ Work Phone: _____

Department: _____ Job Title: _____

Hire Date: _____ Date Joined SLOCEA: _____

1. Describe your emergency situation. Give as much detail as possible (when did the emergency occur or begin, who is affected, etc.) **Attach any receipts, bills, or other available proofs, or your application may be delayed.**

_____

_____

_____

_____

2. Identify any other factors that have made this emergency even more difficult for you.

_____

_____

_____

_____

3. How much money are you requesting? _____

4. Can you name someone who can verify this emergency?

Name: _____ Phone: _____

5. List all income received or anticipated by all household members during this month. Please provide copies of **all** check stubs.

$_____ $_____ $_____ $_____ $_____

Total household income (all income of all household members): $_____

Number of persons dependent on income (in addition to self): _____

Amended by Board of Directors September 15, 2010.

6. List your total expenses for the month. Attach a copy of each bill and briefly identify:

Rent/Mortgage:	_____	_____	_____
Car payment(s):	_____	_____	_____
Insurance Policies:	_____	_____	_____
Food:	_____	_____	_____
Utilities:	_____	_____	_____
Other Expenses:	_____	_____	_____

Total Monthly Expenses: $_____

Other sources of assistance that you should investigate include:

County Red Cross 543-0696 **EOC** 489-5039 **Food Bank** 238-4664

United Way of SLO 541-1234 **County Department of Social Services** 781-1600

County Employee Assistance Program (credit and personal counseling, legal/financial advice, alcohol/drug abuse) 800-999-7222 – free and confidential

Make sure your application is filled out completely. The only information that will be considered is what you have put on your application. All information is strictly confidential.

I hereby certify that the information I have given above is true and correct. I have been given a copy of the Member Benefit Fund rules and understand them.

Signature: _____ Date: _____

※※※※※ Do not write below. You may attach additional pages to give more information if necessary.※※※※※

Date received: _____ Date completed: _____

☐ Approved ☐ Denied Authorized by: _____

Amount Approved: _____ Check #: _____

Reason for Denial: ☐ Insufficient information – return to applicant

☐ Does not meet guidelines of fund criteria

☐ Other (describe): _____

Amended by Board of Directors September 15, 2010.