For Office Use Only: Case ID# ___________________

UAB Benevolent Fund EEAP Intake Form

CONFIDENTIALITY - This form is for OFFICE USE AND STATISTICAL REPORTING ONLY and may not be disclosed except with specific consent. Confidential information will only be disclosed without consent if you reveal the potential of physical harm to self or someone else OR IN THE EVENT OF FRAUD. I understand that a copy of my application will be retained for UAB Benevolent Fund EEAP records.

______ **Initial here** to give the Benevolent Fund authorization to communicate with your Human Resources Department and Benefits office to determine eligibility for assistance through EEAP and to explore avenues of additional assistance.

I. General Information

Name:____ SSN:__________________________

Also Known As:_____________________________ UAB Employee # (located on payslip):_____________

Address:____

City State Zip

Home Phone:___________________ Work Phone:_________________ Cell Phone:_________________

Email: ____

Date of Birth: ____/____/____ Sex (circle one): Male Female Race:_________________________

Marital Status (circle one) : Single Married Divorced Separated Widowed

List all members of your household other than yourself, including roommates:

Name	*Age*	*Occupation*

Have you ever asked for assistance from the UAB Benevolent Fund EEAP? __Yes __No

Person to contact in the event of emergency:______________________________ Phone:__________________

II. Employment Information

Position/Title:____ Hire Date: ____/____/____

Years Employed at UAB:________Status (circle one): Full-time Part-time Retired Disability Leave

Current # Hours Worked Per Week:_____________ Current Rate of Pay:__________________________

Who pays you? (please circle only one):

UAB HSF (Health Services Foundation) Callahan Eye Foundation Health System Viva

Where do you work? (please circle only one):

Callahan Eye Foundation Health System HSF (Health Services Foundation) Kirklin Clinic

UAB Highlands UAB Hospital UAB University/Academic/Administration Viva

I HEREBY CERTIFY THAT THE ABOVE INFORMATION AND ALL INFORMATION PRESENTED REGARDING MY REQUEST FOR ASSISTANCE IS CORRECT. I understand that any deliberate misrepresentation or withholding of facts will be considered fraudulent and will be grounds for disqualification. If I am awarded assistance based on lost wages and I receive sick leave donations, I understand that I must immediately notify the Benevolent Fund because this could greatly impact my assistance award. Failure to notify the Benevolent Fund of such donations is considered fraud. Additionally, **I UNDERSTAND THAT ANY ASSISTANCE AWARDED TO ME BY THE BENEVOLENT FUND IS CONSIDERED TAXABLE INCOME BY THE IRS AND WILL BE REPORTED TO THE IRS AS SUCH.**

Signature:____ Date:_________________________