CORONAVIRUS EMERGENCY HARDSHIP FUND

Submit completed application and supporting documents to:

hardship@ufcw1059.com 614.237.7787 4150 E. Main Street, Columbus, OH 43213

MEMBER INFORMATION

First Name: _____ Last Name: _____

Home Address: _____ Cell: _____

_____ Email: _____

_____ Last 4 digits of SSN: _____

Employer: _____ **Total Payment Requested:$**_____

(maximum $200/member)

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): _____

_____

_____

_____

_____

_____

_____

_____

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 1059 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 Paul Smithberger and Lloyd Blake of the United Food & Commercial Workers Union Local 1059.

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 1059 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: _____