



WESLEY WOODS  
*leaders in senior living*

## Employee Hardship Program Application Packet

**Please complete all portions of the application. If something does not apply, please put N/A.** If you have questions about the application, please contact Human Resources.

Please fax your completed application and supporting documentation to Human Resources at 404-728-6214 or scan and email your completed application to [hr@wesleywoods.org](mailto:hr@wesleywoods.org). **Incomplete or illegible applications will be returned for resubmission.** The Employee Hardship Committee will review the completed application and respond as quickly as possible. **Application information will be kept confidential.**

The information asked on the application is necessary in order to ensure fair and equitable administration of the program and distribution of the funds.

### Section A

Employee Name:	_____	Employee ID:	_____
Home/Cell Phone:	_____	Work Phone:	_____
Job Title:	_____	Department:	_____
Supervisor Name:	_____	Date of Hire:	_____
FT or PT:	_____	Hours per week:	_____
Marital Status:	_____		_____
Spouse Name:	_____	Spouse Phone:	_____
Spouse's Employer:	_____	FT or PT- Spouse	_____
Spouse Job Title:	_____	Hours per week:	_____
Hours per week:	_____	Date of Hire:	_____



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Members living in your household: Relationship to employee, i.e., spouse, child, etc.	Age(s)
_____	_____
_____	_____
_____	_____
_____	_____

Have you previously received PTO hours from the Employee Hardship Program?  Yes  No

If so, when \_\_\_\_\_ Total amount of hours received \_\_\_\_\_

**Employee Hardship Explanation**

**Section B**

Please describe in detail the reason you are requesting assistance. It is necessary that the committee know all the facts related to the events surrounding the employee's hardship. (Use separate sheet if necessary)

(Please write legibly)

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### Authorization

#### Section C

I, the applicant, give permission to release the information I have provided to the Employee Hardship Committee members.

I understand that application to the program does not guarantee that assistance will be provided. I also understand in order to receive assistance:

I must meet the following conditions:

- Be a regular, full-time employee or regular part-time employee in good standing who is scheduled to work 20 or more hours per week for Wesley Woods Senior Living, Inc.
- Be an employee who has not been suspended or received a final written warning in the last 12 months from date of application.
- Be an employee who has completed 90 days of employment.
- Has a hardship that involves the Wesley Woods Senior Living, Inc. employee or a member of the employee's family as defined in the "Employee Hardship Comprehensive Leave Program Policy"

I understand if I falsify or submit fraudulent information, I will be required to repay the amount of money awarded from donated PTO hours and it will be grounds for termination.

I understand a decision of whether donated PTO hours will be granted will be made as quickly as possible after receipt of the completed application and required supporting documentation (excluding Saturday, Sunday and Holidays). Wesley Woods Senior Living, Inc. reserves the right to change or eliminate this program at any time. Any change or modification is subject to administrator approval.

Employee Signature:

Date:

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**Review and Approval**

**Section D**

Approval Section (For HR Purposes only)	
Completed Application received by:	Date Received by HR Hardship Committee:
Committee: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date: _____



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### Comprehensive Leave Donor Form

**Please complete all portions of the Comprehensive Leave Donor Form.** PTO donations will be deducted from your PTO balance and given to the designated recipient upon approval of the Employee Hardship Fund Application. Completed forms can be faxed to HR at 404-728-6214 or scanned and e-mailed to [hr@wesleywoods.org](mailto:hr@wesleywoods.org).

#### Donor Information:

Last Name:	First Name:	Employee ID:
Street Address:		Phone:
City, State, Zip Code:		Department:

#### Donation Information:

*PTO donations must be at least 8 hours but not to exceed 120 hours. Donors must retain a minimum of 80 PTO hours after the donation is made.*

Please indicate the total number of PTO hours that you are donating: \_\_\_\_\_

#### Recipient Information:

Last Name:	First Name:	Department:
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*I have read and understand the provisions of the WWSL Comprehensive Leave Donation Policy before signing this document. I understand that completion of this form is not a guarantee of approval.*

Donor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HR Signature: \_\_\_\_\_

Date: \_\_\_\_\_