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

MEMBER BENEFIT FUND POLICY

A. QUALIFYING EVENT:

1. Any SLOCEA member in good standing may apply for a financial assistance grant (Grant) under this policy for any qualifying event.

2. Qualifying events under this policy include but are not limited to:

   i. Accidental fire or flood, or fire or flood which occurs through circumstances beyond the control of the applicant;

   ii. Catastrophic illness or injury where the illness or injury 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;

   iii. 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.

   iv. 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, registered domestic partners.

B. **APPLICATION PROCESS:**

Members shall apply for a Grant under this policy by submitting their completed application on the form prescribed by the Member Benefit Fund Committee (MBFC).

1. All information collected or reviewed by SLOCEA staff, Directors, and/or committee members, shall be held in strict confidence.

C. **GRANT APPROVAL:**

1. Grants requested under this policy shall in all cases require the approval of the MBFC.

2. The MBFC may approve any Grant application, or combination of applications, up to the cumulative total of the Member Benefit Fund budget approved by the Board of Directors for a given Fiscal year.

3. No member may apply for an Assistance Grant under this policy more than one time per Fiscal year.

4. No member may receive an Assistance Grant under this policy more than one time in a 36 month period.

D. **GRANT GENERAL:**

1. The MBFC shall review and approve Grant requests in accordance with this policy and the MBFC Charter adopted by the Board of Directors.

2. Grants approved under this policy are not loans and no requirement exists for repayment.

3. Whenever possible, SLOCEA checks shall be payable directly to the entity or vendor which is the source of the emergency relief being sought by the applicant.

E. **DENIAL / APPEAL:**

1. If an application is denied the applicant may appeal such denial to the Board.

2. Such appeal shall be submitted in writing to the Association president within ten business days of the denial of the Grant application.

3. Written appeals received by any SLOCEA staff member shall be deemed timely received by the Association president.

4. Appeals that have been timely received shall be placed on the Board's agenda for review at the next regularly scheduled meeting of the Board following the receipt of the appeal.

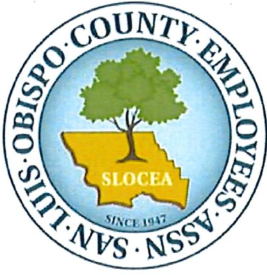
5. Member Benefit Fund appeals shall be heard in a confidential closed session of the Board.

6. The Board shall render a decision to either uphold the MBFC decision or set the decision aside and approve the application on appeal.

7. The determination of the Board is final, binding, and shall be communicated to the appellant in writing within five days of the Board's action.

F. REPEAL / MODIFY:

The Board retains the right to alter, amend, replace, or repeal this policy at any time and without prior notice.



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APPLICATION CRITERIA

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

Other sources of assistance that you should investigate

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

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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.**

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

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3. How much money are you requesting? ______________________________________

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

Name: __________________________________ Phone: _______________________

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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): __________

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: $__________

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): ______________________________