



ACTS REQUEST FORM

(Action, Compassion, Teamwork, Support)

FAX THIS FORM TO: 866-401-3059



SECTION I (Contact Information)

Nominated Colleague: _____ Date of request: _____ Wk phone #: _____

Division: _____ Business unit: _____ Location: _____

Manager: _____ Manager's work phone #: _____

Hire Date: _____ Marital status: _____ PTO/FMLA bank balance: _____

Employment status: Active LOA FMLA Has employee received PTO donations? Yes No

Check type of assistance requested: Housing Medical Utilities Food Other

SECTION II (Natural Disaster related requests)

Please indicate type of disaster: Fire Flood Other _____

Do you have homeowner's or renter's insurance? Yes No

Has assistance from Red Cross or any other agency been received? Yes No

If you checked "Yes", what is the amount or type of assistance you have received? \$ _____

SECTION III (Medical Needs related requests)

Medical condition is that of: Employee Spouse Dependent Child Other _____

Insurance coverage: Medical Dental Short Term Disability Long Term Plus

Other insurance coverage: Medicare Medicaid Spouse's Plan Other _____

If employee or spouse is on LOA, what is the anticipated return-to-work date? _____

SECTION IV (Financial Resources)

Other resources available to you: Savings Bank or 401(k) loan None

Is there another adult living in your household? Yes No

If YES, how is this person contributing to your need? _____

Employee's bi-weekly salary: \$ _____ Spouse's salary (if applicable) \$ _____

