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Rachelle Dethloff, Benefits
Carrie Riley, Payroll

2026-2027 HARDSHIP ADVANCE FOR MEDICAL REASONS

With the implementation of the District's High-Deductible Health Plan, we are aware that having to pay a Deductible of $3,400 per individual/$6,800 family (2026-2027) can cause financial hardship upon an individual, especially if incurred early in the plan year.

To help alleviate some of the financial strain that may come with this change, the District will allow Hardship Advances from HSA contributions on a case-by-case basis. To qualify for a Hardship Advance, the following conditions must be met:

- There must be a Medical Bill for an individual covered under the District's Medical Insurance Policy exceeding $1,000.
- Hardship Advances will range from $500-$3,400.
- The employee must have been employed with the District for at least thirty days.
- The attached agreement must be signed prior to a check or direct deposit being issued.
- The employee must agree that HSA contributions will be adjusted to reflect the advance.
- Payment will be made during the next available payroll cycle.

Sincerely,

Rachelle Dethloff

Benefits Coordinator

I, (Printed Name) _____ ,
agree that I will continue working for the District through the end of my Certified year. I am aware that by receiving this advance, I will not be receiving part/any of my future District contributions into my HSA until the balance of the advance has been offset. I agree that the debt I owe will be paid in full by the end of my Certification. If my payment will not be paid in full by the time my Certification has lapsed, the remaining amount will be taken from my final check(s). If I terminate during the middle of my Certification, I agree to have the remaining balance of my advance taken from my final paycheck(s). I agree that I meet the hardship criteria.

Amount Requested: _____

Employee Signature: _____

Date: _____

(Employer Will Complete)

Certification Start Date: _____

Certification End Date: _____

Amount of Hardship Advance: _____

Balance Remaining: _____

Number of Checks Remaining: _____

Employer Signature: _____

Date: _____