CHRISTIAN SCIENCE NURSING CARE ENDOWMENT

SOUTHERN CALIFORNIA

APPLICATION FOR FINANCIAL ASSISTANCE

Date prepared _____________________

Note: *Applications will be considered that have been fully answered Our desire is to offer financial assistance to students of Christian Science who are expecting and working for spiritual healing and have very limited sources to pay for nursing care. The information presented will be held in strictest confidence and will be verified. This application must be signed by the applicant or by person submitting the application for the applicant, and by the facility administrator or by nurse providing the services. The financial data on the reverse side must be completed for the application to be processed. Each request is handled on an individual basis. The information provided will help determine the amount of assistance required.*

General Information about the Applicant

Name: ____

Address: ____

City ____ State______________ Zip ___________________

Telephone: ( ) ________________________ E-mail: ____

Mother Church Member ___Yes ___No

Branch Church Member of ____

Is a Journal-listed Christian Science Practitioner working for you?

__Yes __No Telephone number: ( ) __________________________________

How long have you resided in southern California? ____

Are you a:

__ Journal-listed Christian Science Practitioner? How many years? ____________

__ Journal-listed Christian Science Nurse? How many years? ____________

Would you please give two references (not family members) who are members of The Mother Church, and who are acquainted with your life and work as a Christian Scientist:

Name: ____

Telephone (____)_________________________________

Name: ____

Telephone (____)_________________________________

FINANCIAL ASSISTANCE

How much are you able to pay of your monthly care cost? ________________________

How long can you make these payments? ______________

Are family members able to assist with these costs? ____ If so, how much? ___________

Are you able to receive assistance from your Christian Science Association? ____ If so, how much? ________

Are you able to receive assistance from your Church's care committee? ____ If so, how much? ________

How much assistance are you requesting? ___________

INFORMATION ABOUT ACCREDITED FACILITY OR JOURNAL-LISTED NURSE PROVIDING HOME CARE

Name of facility or nurse providing care: ____

Telephone (____) _______________________

Address

____

Date when nursing care commenced, or entered CS facility: _____________________________

Name of person submitting this application (if not patient): ________________________________

Telephone (____) _______________

Relationship to patient ____________________________________

Date ____

Signature ____

TO BE COMPLETED BY THE FACILITY WHERE PATIENT IS RESIDING OR BY THE NURSE PROVIDING HOME CARE

Applicant's level of care ____

Total monthly cost ______________________________________

What portion of the total monthly cost is attributable to nursing? _________________________

Is the facility depending upon Medicare? ___ Yes ___ No

MediCal? ___ Yes ___ No for this patient?

In the judgment of the facility or nurse, is patient radically relying on Christian Science? ___ Yes ___ No

Signature of the facility administrator or nurse ____

Date _____________________________

FINANCIAL INFORMATION

Information about Assets and Liabilities

ASSETS		**LIABILITIES**	
Checking accounts	$ ___________	Unpaid Bills - list	$ ___________
Savings accounts	$ ___________		$ ___________
Securities (market value)	$ ___________		$ ___________
Residence (market value)	$ ___________	Mortgage	$ ___________
Other assets (property, Insurance, etc)	$ ___________	Other loans	$ ___________
Total Assets:	$ ___________	**Total Liabilities:**	$ ___________
	$ ___________		**$** ___________

SOURCES OF MONTHLY INCOME AND/OR RECEIPTS

Insurance that may help with your care $ ___________

Pension Income $ ___________

Social Security $ ___________

Spouse income, pension and Social Security $ ___________

Other Income $ ___________ *(please describe)*

____

Other Assistance $ ___________ *(Churches, Associations)* Frequency of payments:

____

SUMMARY OF MONTHLY EXPENSES

Household $ ___________ *(please describe)*

____

Insurance expenses - care $ ___________

Care expenses $ ___________ What percent relates directly to nursing care? _______%

Other expenses $ ___________ *(please describe)*

____

____

INCOME TAX INFORMATION

Did you file tax returns for either or both of the last two years? ___Yes ___No

If you filed, please attach copies of your last two years' tax returns.

Attached is a release form authorizing us to obtain your federal returns for the past two years.

Please sign the release as a part of this application.

PLEASE UNDERSTAND THAT YOUR APPLICATION CANNOT BE PROCESSED UNLESS THE PERTINENT FINANCIAL DATA HAS BEEN RECEIVED AS OUTLINED ABOVE.

OTHER INFORMATION - If there is any other information, which you believe will be of benefit to evaluate this application?

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AFTER COMPLETION OF THE APPLICATION

The Facility (or nurse providing home care) should forward the completed and signed application to:

Christian Science Nursing Care Endowment
P.O. Box 2895
Seal Beach, CA 90740