**CHRISTIAN SCIENCE NURSING CARE ENDOWMENT**

**SOUTHERN CALIFORNIA**

(Southern California is defined by the zip code range of 90000 to 93599.)

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 sp0iritual 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother Church Member \_\_\_\_Yes \_\_\_\_No

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Branch Church Member of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_

Telephone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is a Journal-listed Christian Science Practitioner working for you? \_\_\_\_Yes \_\_\_\_No Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you resided in southern California? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a Journal-listed Christian Science Practitioner? \_\_\_\_ 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 costs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please complete reverse side for additional financial data)**

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

Name of facility or nurse providing care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone ( )\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

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 total monthly cost are attributable to nursing?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the facility depending on Medicare? \_\_\_\_Yes \_\_\_\_No Medical? \_\_\_\_Yes \_\_\_\_No (for this patient?)

In the judgment of the facility or nurse, is the 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 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other loans $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance, etc.) $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, or

C.S. Associations etc.) $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency of payments\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF MONTHLY EXPENSES

Household $\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance expense – 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.**

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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AFTER COMPLETION OF THE APPLICATION

The completed and signed application may be mailed to:

**Christian Science Nursing Care Endowment**

**P.O. Box 5621**

**Pasadena, CA 91117**

Or scanned and emailed to: [csnurscare@gmail.com](mailto:csnurscare@gmail.com).