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 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_____ 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 _____

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 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 _____

P.O.Box 2895 - Seal Beach, CA 90740 - CSNurscare@aol.com - (714) 687-5313

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. 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 comopleted and signed application to

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

5/10/02