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?

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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 5621

Pasadena, CA 91117