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_____ 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. 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?

_____
_____

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