



Nurses House

The Veronica M. Driscoll Center for Nursing
 2113 Western Avenue, Suite 2 Guilderland, NY 12084-9559
 (518) 456-7858 ext 25 Fax: (518) 452-3760
mail@nurseshouse.org www.nurseshouse.org

Please PRINT CLEARLY!
Thank you.

APPLICATION FOR ASSISTANCE

Ms ___ Miss ___ Mrs ___ Mr ___ Dr ___

NAME: _____
Last First Middle

ADDRESS: _____
Street City State Zip Code

TELEPHONE #: () _____ **E-MAIL ADDRESS:** _____

BIRTHDATE: ___/___/___ **MARITAL STATUS:** S ___ M ___ Sep ___ D ___ W ___

RN LICENSE #: _____ **STATE:** _____ **EXPIRATION DATE:** ___/___/___
 (Please enclose photocopy of RN license or registration)

SCHOOL OF NURSING: _____
Name

ADDRESS: _____
Street City State Zip Code

GRADUATION DATE: ___/___/___
HIGHEST LEVEL OF EDUCATION: Diploma ___ AA ___ BS ___ MA/MS ___ Doctorate ___

SOURCE OF REFERRAL TO NURSES HOUSE: _____

HAVE YOU APPLIED FOR NURSES HOUSE ASSISTANCE BEFORE? Y ___ N ___

If so: When? _____ **Under what name?** _____ **Were you approved?** Y ___ N ___

TOTAL # of DEPENDENTS (under age 18): _____ **Child Support** **Full Time Student**

Age	Gender	Relationship	Y or N	Y or N
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Age	Gender	Relationship	Y or N	Y or N
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Age	Gender	Relationship	Y or N	Y or N
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CONTACT PERSON (other than self) FOR EMERGENCY PURPOSES ONLY

NAME: _____
Last First Middle

_____ Street City State Zip Code

RELATIONSHIP: _____ **TELEPHONE:** () _____

HOUSING ARRANGEMENTS: Shelter ___ Homeless ___ Live in own rented dwelling ___

Live in own mortgaged dwelling ___ Live in another's dwelling ___

OF PEOPLE IN HOUSEHOLD AND AGES _____

EMPLOYMENT STATUS: Employed: Y/N ____ Full Time ____ Part Time ____
Short Term/Temp Disabled ____ Long Term/Permanently Disabled ____

ANTICIPATED RETURN TO WORK DATE: ____/____/____ Part Time ____ Full Time ____

Limitations: _____

MOST RECENT EMPLOYER: _____
Name

Street City State Zip Code

YOUR EMPLOYMENT POSITION _____

Employed from: ____/____/____ **to** ____/____/____ **Last salary check** ____/____/____
Date Last Day Worked Date

IF NECESSARY, MAY WE CONTACT EMPLOYER? Yes ____ No ____

Contact Name: _____ Telephone (____) _____

BRIEFLY SUMMARIZE PRESENT INABILITY TO WORK
(Attach additional sheets as required) **Diagnosis/es:** _____

Current Health Status & Treatment Regime _____

Additional Pertinent Information _____

ATTENDING PHYSICIAN _____ (____) _____
Name Telephone

Street City State Zip Code

IF NECESSARY, MAY WE CONTACT PHYSICIAN? Yes ____ No ____

FINANCIAL RESOURCES

**A. MONTHLY INCOME
SOURCE**

**MONTHLY
AMOUNT**

EFFECTIVE DATES

**Applicant salary, when working
(Take home pay per month)**

Spouse's salary, if applicable (Take home/mo)

(Please attach a copy of applicant's & spouse's most recent W 2)

Self-Employment (attach W2 form)

Short Term Disability

Other Long Term Disability

Social Security Benefits

Spousal Social Security Benefits

Social Security Disability

Worker's Compensation

Unemployment Benefits

Public Assistance

Food Stamps

Pension or Annuity

Child Support

Alimony

If anyone in the household other than you or your spouse receive an income, please note here: _____

B. BANK ACCOUNT BALANCES Checking _____ Savings _____

C. RETIREMENT RESOURCES Yes ____ No ____ if yes, detail below

STOCK/BONDS Yes ____ No ____ if yes, detail below

RETIREMENT FUNDS STOCKS/BONDS NAME NUMBER VALUE

D. PROPERTY/REAL ESTATE Yes ____ No ____

Address including rental properties _____

Outstanding balance for each piece of property owned _____

Market Value _____ Annual Taxes _____ Mo Mortgage Payment _____

E. HEALTH INSURANCE: Employer _____ COBRA _____ Medicaid _____ Medicare _____
 Other source _____

OTHER POTENTIAL RESOURCES Yes _____ No _____

<u>DATE</u>	<u>AMOUNT</u>	<u>SOURCE</u>	<u>POTENTIAL RESOURCE</u>
_____	_____	Relative	_____
_____	_____	Friend	_____
_____	_____	Community Agency	_____
_____	_____	Church	_____
_____	_____	Insurance Settlement	_____
_____	_____	Other Income	_____

If you have not received a paycheck, or other financial assistance in over 60 days, please help us understand how you have been surviving financially. _____

<u>F. STATUS OF APPLICATIONS</u>	<u>Date Filed</u>	<u>Response Date</u>	<u>If denied – reason</u> <u>If approved – amount – dates</u>
Short Term Disability	_____	_____	_____
Other Long Term Disability	_____	_____	_____
Social Security Benefits	_____	_____	_____
Social Security Disability	_____	_____	_____
Worker’s Compensation	_____	_____	_____
Medicare	_____	_____	_____
Medicaid	_____	_____	_____
Unemployment Benefits	_____	_____	_____
Public Assistance	_____	_____	_____
Food Stamps	_____	_____	_____
Pension or Annuity	_____	_____	_____
Other _____	_____	_____	_____

G. AVERAGE MONTHLY EXPENSES

<u>BASIC ITEMS</u>	<u>Monthly Amount</u>	<u>Current Y or N</u>	<u>If Not Current # of Months</u>	<u>Exact Amount in arrears</u>
Rent	_____	_____	_____ months.....\$	_____
Mortgage	_____	_____	_____ months.....\$	_____
Second Mortgage	_____	_____	_____ months.....\$	_____
Food for #____ persons	_____	_____	_____ months.....\$	_____
Electricity	_____	_____	_____ months.....\$	_____
Heat	_____	_____	_____ months.....\$	_____
Water	_____	_____	_____ months.....\$	_____
Telephone	_____	_____	_____ months.....\$	_____
<u>OTHER NECESSARY ITEMS</u>				
Health Insurance Premium	_____	_____	_____ months.....\$	_____
Medications	_____	_____	_____ months.....\$	_____
Medical Expenses	_____	_____	_____ months.....\$	_____
Auto Payment	_____	_____	_____ months.....\$	_____
Auto Insurance	_____	_____	_____ months.....\$	_____
Gas	_____	_____	_____ months.....\$	_____

Please include all other miscellaneous expenses below, including all credit cards, school loans

If rent/mtge in arrears, is eviction notice or foreclosure threatened?

No _ Yes _ Verbal _ Written _ If yes, explain _____

Are you near a bus line? Yes _____ No _____

Is auto necessary? Yes _____ No _____ If yes, explain _____

Have you declared bankruptcy? No _____ Yes _____ If yes, Date: _____

If yes or considering, explain _____
