



# Senior Charity Care Foundation

## APPLICATION FOR ASSISTANCE

Name of Applicant:	_____	Date:	_____
Apartment Name:	_____	Marital Status:	_____
Apartment Address:	_____	Apartment number:	_____
City, State, Zip:	_____	Applicant's Phone:	_____
Legal Resident of Utah?	_____	Birthdate: M/D/Y	_____
Responsible Party's Name:	_____	Relationship:	_____
Responsible Party's Address:	_____	Phone:	_____
City, State, Zip:	_____		

**Please circle what you need:**               Dental Care               Eyeglasses               Hearing Aids

<b>Income</b>	<b>Monthly</b>	<b>Assets (Value):</b>	
Social Security	\$ _____	House	\$ _____
Pensions, IRA's Etc.	\$ _____	Other Property	\$ _____
Trusts, Others	\$ _____	Life Insurance	\$ _____
Veteran's Admin.	\$ _____	Investments	\$ _____
Family	\$ _____	Savings	\$ _____
Facility Discount	\$ _____	Money Owed to Me	\$ _____
Other: _____	\$ _____	Other: _____	\$ _____
<b>Total Income:</b>	<b>\$ _____</b>	<b>Total Assets:</b>	<b>\$ _____</b>

<b>Expenses:</b> <b>(For Long Term Care and Assisted Living)</b>	<b>Expenses:</b> <b>(For Independent Apartments)</b>		
<b>Monthly</b>	<b>Monthly</b>		
Facility Charges	\$ _____	Facility Rent	\$ _____
Medications	\$ _____	Food	\$ _____
Physicians	\$ _____	Transportation*	\$ _____
Clothes, Toiletries	\$ _____	Utilities	\$ _____
Other _____	\$ _____	Medications	\$ _____
<b>Total Expenses</b>	<b>\$ _____</b>	Physicians	\$ _____
		Clothes, Toiletries	\$ _____
		Other _____	\$ _____
		<b>Total Expenses</b>	<b>\$ _____</b>

\* Transportation expenses include care and related expenses such as maintenance and insurance, local bus fare or passes, or local taxi fares. Transportation expenses do not include air travel, train travel or other long distance modes of transportation.

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**(PAGE 2)**

Please provide the following documents, if applicable, (If not applicable write N/A in Space provided)

- 1. Last three (3) years 1040 filings to the IRS; \_\_\_\_\_
- 2. If a home or other real estate is owned, property tax notices; \_\_\_\_\_
- 3. Gift tax returns filed with the IRS during the previous three (3) years. \_\_\_\_\_

**Certification:**

I certify that the above information is true and accurate, to the best of my knowledge. I understand that Senior Charity Care Foundation is only for residents of senior facilities who do not have the financial resources to pay the total cost of their care and services at a skilled nursing facility, assisted living facility or independent senior apartments. Further, I will make application for any assistance (Medicaid, Medicare, Veteran’s Administration, etc.) which may be available for payment of my (or the above named resident’s) bills. Therefore, if additional income or assets become available, I will notify the Foundation President promptly. I also understand that if I (or the above named resident) am accepted as a Charity Care recipient, I may be asked to sign an obligatory note.

**Signature**

**Date:**

*If the senior is unable to sign for themselves:*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

***Please mail application to 721 North Main Street #106, Layton UT 84041***

# 2021 Required Demographic Questions

Name:

Q. What is your sex?  Male  Female  Transgender  Binary  Prefer Not to Say

Q. Do you have transportation?  None  Self  Family  Transportation Company

Q. What is the highest degree or level of school you have completed?

- Did not complete High School
- High school graduate - high school diploma or the equivalent (GED)
- Bachelor's degree (for example: BA, AB, BS) or higher
- Unreported or Unknown

Q. What is your total annual household income?

**If Single:**

- Less than \$12,888
- \$12,889-17,130
- \$17,131-19,320
- \$19,321-25,760

**If Married:**

- Less than \$17,420
- \$17,421 - \$23,169
- \$23,170-26,130
- \$26,131-34,840

Q. Do you have any dental insurance?  Yes  No

If "Yes" Please list: \_\_\_\_\_

Q. Do you have Medicaid?  Yes Medicaid Number \_\_\_\_\_  No

Q. Do you have Medicare?  Yes  No

Q. Do you have a disability?  Yes  No If yes, please check type below:

- Ambulatory Difficulty  Cognitive Difficulty  Hearing Difficulty
- Independent Living Difficulty  Self-Care Difficulty  Vision Difficulty
- Other:

Q. Please specify your race

- American Indian or Alaska Native alone
- Asian alone
- Black or African American alone
- Native Hawaiian or Other Pacific Islander alone
- White/Caucasian alone
- Two or more races
- Unreported or Unknown

Q. Do you identify as Hispanic or Latino?  Yes  No

Q. What is your primary language?

English  Spanish  French  German  Chinese  Other: \_\_\_\_\_

Q. Are you a veteran?

- Yes  No