



Internal Use Only

___ PD ___ AL ___ OD ___ DM

APPLICATION FOR ASSISTANCE

Name of Applicant: _____ Today's Date: _____
Apartment Name: _____ Birthdate (M/D/Y): _____
Apartment Address: _____ Apartment Number: _____
City, State, Zip: _____ Applicant's Phone: _____
Email: _____

Please circle what services you need: Dental Care / Eyeglasses / Hearing Aids

Table with 2 columns: Income (Monthly) and Assets (Total Value). Rows include Social Security, Pensions, Trusts, Veteran's Admin, Family, Working Wages, Other, House, Other Property, Life Insurance, Investments, Savings, Money Owed to Me, Other.

Table with 2 columns: Expenses (Monthly). Rows include Facility Rent, Food, Transportation, Utilities, Medications, Other, Total Expenses.

Please Select Your Type of Housing
___ Long-term Care/Assisted Living
Apartments:
___ HUD ___ Seniors ___ All Ages
House:
___ Own ___ Family ___ Rent

Signature: _____ Date: _____

If the senior is unable to sign for themself:

Signature: _____ Date: _____ Relationship: _____

Phone #: _____ Email: _____

Address: _____

Please mail application to 721 North Main St #106, Layton, UT 84041 or email to seniorcharitycarefoundation@gmail.com

2023 Required Demographic Questions

Print 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 your marital status? Married Single Divorced Widowed

Spouse (If Married): _____

Q. Are you a veteran? Yes No

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. 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. What is your ethnicity or race? Please check all that apply.

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

Q. What is your primary language?

English Spanish French German Chinese Other: _____