Senior Charity Care Foundation

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**

Income	*Monthly*	**Assets**	*Total Value*
Social Security	$	House	$
Pensions, IRA's Etc.	$	Other Property	$
Trusts, Others	$	Life Insurance	$
Veteran's Admin.	$	Investments	$
Family	$	Savings	$
Working Wages	$	Money Owed to Me	$
Other: _____	$	Other: _____	$
Total Income:	**$**	**Total Assets:**	**$**

Expenses	*Monthly*
Facility Rent	$
Food	$
Transportation	$
Utilities	$
Medications	$
Other	$
Total Expenses:	**$**

Please Check Your Type of Housing

☐ Long-term Care/Assisted Living

☐ Independent Apartments

Signature: _____ **Date**: _____

If the senior is unable to sign for themself:

Signature: _____ Date: _____ Relationship: _____

Phone #: _____ Email: _____

Address: _____

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

2022 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

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. What is your total annual household income?

If Single:	**If Married:**
☐ Less than $12,888	☐ Less than $17,420
☐ $12,889-17,130	☐ $17,421 - $23,169
☐ $17,131-19,320	☐ $23,170-26,130
☐ $19,321-25,760	☐ $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. 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:_____