



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:	_____		

Need (Reason for Application): Dental Care Eyeglasses Hearing Aids

Income	Monthly	Assets (Value):	
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: _____	\$ _____

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

* 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.

2020 Required Demographic Questions

Name: _____

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

Q. Are you age 55-59 60-64 65-69 70-74 75-79 80+

Q. Are you Married or Single

Q. Are you a Utah resident? Yes No

Q. What is your Zip Code? _____

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 \$12,760
- \$12,760 - \$16,971
- \$16,971 - \$18,735
- \$18,735 - \$24,980

If Married:

- Less than \$17,240
- \$17,240 - \$22,929
- \$22,929 to \$25,365
- \$25,365 to \$33,820

Q. Do you have any dental insurance? Yes No

If "Yes" Please list: _____

Q. Do you have Medicaid? 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

APPLICATION FOR ASSISTANCE

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. _____

Person providing Information:

Name: _____ Relationship: _____

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: _____

Please complete in full and return to Senior Charity Care Foundation. We will get back to you in a timely manner.

Senior Charity Care Foundation
1555 West 2200 South Suite B
West Valley, UT
84119