Please PRINT CLEARLY!
Thank you.

Nurses House

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

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

_____ _______ ________________________________ ____________ ______________
Age Gender Relationship Y or N Y or N

_____ _______ ________________________________ ____________ ______________
Age Gender Relationship Y or N Y or N

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:** ______________________________

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Current Health Status & Treatment Regime ____________________________________

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Additional Pertinent Information ____

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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 _____**

DATE	AMOUNT	SOURCE	POTENTIAL RESOURCE
___________	___________	**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.________________________

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____

F. STATUS OF APPLICATIONS Source	Date Filed	Response Date	If denied – reason If approved – amount – dates
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

BASIC ITEMS	**Monthly Amount**	**Current Y or N**	**If Not Current # of Months**	**Exact Amount in arrears**
Rent	__________	_______	______months.....	$ ____________________
Mortgage	__________	_______	______months.....	$ ____________________
Second Mortgage	__________	_______	______months.....	$ ____________________
Food for #____ persons	__________	_______	______months.....	$ ____________________
Electricity	__________	_______	______months.....	$ ____________________
Heat	__________	_______	______months.....	$ ___________________
Water	__________	_______	______months.....	$ ____________________
Telephone	__________	_______	______months.....	$ ____________________
OTHER NECESSARY ITEMS				
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

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____

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 ____

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____

ASSISTANCE REQUESTED FROM NURSES HOUSE (Please specify the exact amount & type of assistance you wish Nurses House to consider) ____________________________

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ADDITIONAL INFORMATION (Please offer any additional information pertinent to your circumstances and/or request) ____

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Applicant assures that the information provided herein is true and accurate.

____ ____/____/______

Signature of Applicant **Date**

Please attach photocopy of Current Nursing License and Registration and most recent W-2 from when last worked or Disability Income Report.