Carin for Nurses

Attn: Christy Rock

P.O. Box 910440 Lexington, KY 40591

859-396-7820

www.carinfornurses.org

APPLICATION FOR ASSISTANCE

Ms. ___ Miss ___ Mrs. ___ Mr. ___ Dr. ___

NAME: ____

ADDRESS: ____

TELEPHONE# :(____) _______________E-MAIL ADDRESS: _____________________

BIRTHDATE: ___/___/________ MARITAL STATUS: S ___ M ___ Sep ___ D ___ W ___

NURSING LICENSE #: _______________________ EXPIRATION DATE: ___/___/____

(Please include a photocopy of nursing license)

SOURCE OF REFERRAL TO CARIN FOR NURSES: ______________________________

TOTAL # OF DEPENDENTS (under age 18) ______

Age	Gender	Relationship	Child Support	Full Time Student

CONTACT PERSON: (other than self) FOR EMERGENCY PURPOSES ONLY

NAME: ____

Last First Middle

____

Street City 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 _______

Limitations: ____

ANTICIPATED RETURN TO WORK DATE: ______/_____/_____ Part Time ____ Full Time _____

RECENT EMPLOYER: ____

Name

____

Street City State Zip Code

EMPLOYMENT POSITION: ____

Employed from: _____/_____/_____ to _____/_____/_____ (last day worked)

Last salary check (date) _____/_____/_____

BRIEFLY SUMMARIZE PRESENT INABILITY TO WORK (Attach additional sheets as required)

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____

DIAGNOSIS/ES: ____

____

CURRENT HEALTH STATUS AND TREATMENT REGIMEN: ____________________________

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____

____

CURRENT MEDICATIONS (including over-the-counter): __________________________________

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____

FINANCIAL RESOURCES:

(Please include amounts received by ALL members of the household and provide copies of ALL income and /or benefits.)

MONTHLY INCOME	YOURSELF	SPOUSE/PARTNER	EFFECTIVE DATES
Current Salaries	____________	_____________________	_______________________
Self-Employment	____________	_____________________	_______________________
Short Term Disability	____________	_____________________	_______________________
Long Term Disability	____________	_____________________	_______________________
Social Security Benefits	____________	_____________________	_______________________
Worker's Compensation	____________	_____________________	_______________________
Unemployment Benefits	____________	_____________________	_______________________
Public Assistance	____________	_____________________	_______________________
Food Stamps	____________	_____________________	_______________________
Pension or Annuity	____________	_____________________	_______________________
Child Support	____________	_____________________	_______________________
Alimony	____________	_____________________	_______________________
Church Donations	____________	_____________________	_______________________
From Relatives	____________	_____________________	_______________________
Other Income	____________	_____________________	_______________________

If anyone in the household other than you or your spouse receives an income, please note here:

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____

____

PROPERTY/REAL ESTATE: Yes _____ No ______

Outstanding balance for all property owned ____

Market Value ________________Annual Taxes ______________ Mo. Mortgage Payment _________

Do you receive any rental income from property? Yes _____ No ______

Amount ____

AVERAGE MONTHLY EXPENSES

BASIC ITEMS	**Monthly Amount**	**Current Y or N**	**If Not Current # of Months**	**Exact Amount in arrears**
Rent	___________	______	_________	________________________
Mortgage	___________	_______	_________	________________________
Second Mortgage	___________	_______	_________	________________________
Food for #____persons	___________	_______	_________	_______________________
Electricity	___________	_______	_________	_______________________
Heat	___________	_______	_________	_______________________
Water	___________	_______	_________	_______________________
Telephone/Mobile	___________	_______	__________	_______________________
OTHER NECESSARY ITEMS				
Health Insurance Premiums	___________	_________	__________	_______________________
Medications	___________	_________	__________	_______________________
Medical Expenses	___________	__________	___________	_______________________
Auto Payment	___________	__________	___________	_______________________
Auto Insurance	___________	__________	___________	_______________________
Gas	___________	__________	___________	_______________________

Please include all other miscellaneous expenses below, including all credit cards, school loans

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____

If rent/mortgage is in arrears, is eviction notice or foreclosure threatened?

No ____ Yes ___ Verbal _____ Written _____ If yes, explain ____________________________________

____

____

Have you declared bankruptcy? No ____ Yes ____ If yes, Date: _________________________

If yes or considering, explain ____

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ASSISTANCE REQUESTED FROM CARIN FOR NURSES: Please specify the exact bills and amount of assistance you wish Carin for Nurses to consider. Carin for Nurses will apply the grant directly to the bill for you. Please provide copies for each bill with outstanding balance clearly marked. ____

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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 Kentucky Nursing License and most recent W-2 from when worked or Disability Income Report.