CarinForNurses.org

APPLICATION FOR ASSISTANCE

NAME:											
ADDRESS:											
CITY:		**STATE:**		**ZIP:**							
EMAIL:											
BIRTH DATE:		**MARITAL STATUS:**	S		M		Sep	D		W	
NURSING LICENSE#:		**EXPIRATION DATE:**									
(Please include a photocopy of nursing license)		**PHONE#:**									
SOURCE OF REFERRAL TO CARIN FOR NURSES:											

TOTAL # OF DEPENDENTS (under Age 18):		*Provide details for each Dependent*		
AGE	**GENDER**	**RELATIONSHIP**	**CHILD SUPPORT**	**FULL TIME STUDENT**

CONTACT PERSON (other than self) - ***FOR EMERGENCY PURPOSES ONLY***			
NAME:			
ADDRESS:			
PHONE#:		**RELATIONSHIP:**	

HOUSING/LIVING PROPERTY ARRANGEMENT:				
SHELTER	**HOMELESS**	**RENTAL/APARTMENT**	**OWN/MORTGAGED**	**LIVING IN ANOTHER'S PLACE**
# OF PEOPLE IN HOUSEHOLD:		**PROVIDE AGES:**		

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EMPLOYMENT STATUS:	Employed Full Time		Employed Part Time		Not Employed		
LIMITATIONS:							
ANTICIPATED RETURN TO WORK DATE:			Full Time		Part Time		
MOST RECENT EMPLOYER:							
ADDRESS:							

ROLE/POSITION	START DATE	END DATE	LAST CHECK DATE

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

DIAGNOSIS / ES:

CURRENT HEALTH STATUS AND TREATMENT REGIME:

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.)***

MOTHLY 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			

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

DO YOU OWN PROPERTY/REAL ESTATE?	YES		NO				
OUTSTANDING BALANCE ON ALL PROPERTY OWNED	**MARKET VALUE**		**ANNUAL TAXES**		**MO. MORTGAGE PYMT**		
DO YOU RECEIVE RENTAL INCOME FROM ANY PROPERTY?	YES		IF YES, ENTER AMOUNT:		NO		

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APPLICATION FOR ASSISTANCE

AVERAGE MONTHLY EXPENSES:

Basic & Necessary Items	Monthly Amt	Current (Y or N)	If No, # Mos in Arrears	Exact Amt in Arrears
Rent Payment				
Mortgage Payment				
Second Mortgage Payment				
Food for #_____ persons				
Electricity				
Heat				
Water				
Telephone/Mobile				
Health Insurance Premiums				
Medications				
Medical Expenses				
Auto Payment				
Auto Insurance				
Gas				
Write in other Miscellaneous Expenses below (credit cards, school loans, etc.)				

IF RENT/MORTGAGE IS IN ARREARS, IS AN EVICTION NOTICE OR FORECLOSURE THREATENED?

NO	YES	VERBAL	WRITTEN

If YES, please explain:

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HAVE YOU DECLARED BANKRUPTCY?							
NO		YES		CONSIDERING			
If YES or CONSIDERING, please explain:							

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 of each bill with outstanding balance clearly marked.

ADDITIONAL INFORMATION: Please provide additional information pertinent to your circumstances and/or request.

APPLICANT VERIFICATION AND SIGNATURE

By signing below, the Applicant verifies that the information provided herein is true and accurate.

SIGNATURE OF APPLICANT	**DATE**

SPECIAL NOTE: Please attach a photocopy of current Kentucky Nursing License and most recent W-2 from when worked or Disability Income Report.

PLEASE RETURN YOUR COMPLETED FORM, BY MAIL OR EMAIL, TO:	Carin for Nurses P. O. Box 910440 Lexington, KY 40591	Email Address: **INFO@CFRNS.ORG**
FOR QUESTIONS OR ADDITIONAL INFO:	**CALL: (859) 396-7820**	**VISIT WEBSITE:** www.carinfornurses.org