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. 125
mail@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: ____/____/_____

SOURCE OF REFERRAL TO NURSES HOUSE: ________________________________

HAVE YOU APPLIED FOR NURSES HOUSE ASSISTANCE BEFORE? Y ____ N ____

If yes: Date ________ Name _________________ Were you approved? Y__ N__

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____

TOTAL # of DEPENDENTS (under age 18): ______

Age	Gender	Relationship	**Child Support**	**Full Time Student**
____	______	____________________	Y or N	Y or N
____	______	____________________	Y or N	Y or N
____	______	____________________	Y or N	Y or N

EMPLOYMENT STATUS: Full Time ______ Part Time ______ Retired ______
Short Term/Temp Disabled ______ Long Term/Permanently Disabled ______

CURRENT/MOST RECENT EMPLOYMENT POSITION: ______________________________

Employed from: ___/___/______ **to** ___/___/______ **Last salary check** ___/___/_____
Date Last Day Worked Date

ANTICIPATED RETURN TO WORK DATE: ____/____/____ Part Time ____ Full Time ____
Limitations: ____

IF UNABLE TO RETURN TO WORK, PLEASE EXPLAIN:
____
____
____
____

IS YOUR CURRENT HEALTH SITUATION THE REASON FOR LEAVING YOUR MOST RECENT EMPLOYMENT POSITION? **YES**___________ **NO**____________

BRIEFLY SUMMARIZE PRESENT INABILITY TO WORK:
____
____
____
____
____
____
____
____
____
____
____

MONTHLY INCOME	YOURSELF	SPOUSE/PARTNER	OTHER HOUSEHOLD MEMBER(S)
Current Salaries			
Self-Employment			
Short Term Disability			
Long Term Disability			
Social Security Benefits			
Social Security Disability			
Worker's Compensation			
Unemployment Benefits			
Public Assistance			
Food Stamps			
Pension or Annuity			
Child Support			
Alimony			
Property Income			

OTHER RESOURCES SOUGHT	Date Filed	Response Date	If denied – reason If approved – amount and dates
Short Term Disability			
Long Term Disability			
Social Security Benefits			
Social Security Disability			
Worker's Compensation			
Medicare			
Medicaid			
Unemployment Benefits			
Public Assistance			
Food Stamps			
Pension or Annuity			
Family/Friend			
Church/Community			

MONTHLY **LIVING EXPENSES**	Monthly **Amount**	Current? **Y or N**	# of Months **Behind**	**Amount in Arrears**
Rent/Mortgage/ Property Fees	__________	_______	______months.....	$ ____________________
Second Mortgage/ Home Equity Loan	__________	_______	______months.....	$ ____________________
Food for #____ persons	__________	_______	______months.....	$ ____________________
Electricity	__________	_______	______months.....	$ ____________________
Heat	__________	_______	______months.....	$ ____________________
Telephone	__________	_______	______months.....	$ ____________________

OTHER EXPENSES

Health Insurance Premium	__________	_______	______months.....	$ ____________________
Medications	__________	_______	______months.....	$ ____________________
Medical Expenses	__________	_______	______months.....	$ ____________________
Auto Payment	__________	_______	______months.....	$ ____________________
Auto Insurance	__________	_______	______months.....	$ ____________________
Gas	__________	_______	______months.....	$ ____________________
Bus Fare/Other Transportation	__________	_______	______months.....	$ ____________________

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

No _ Yes _ Verbal _ Written _ If yes, date of eviction/foreclosure ____________________

ADDITIONAL PERTINENT INFORMATION: ____

____

____

____

____

____

____

____

____

NURSES HOUSE WILL PROVIDE ASSISTANCE WITH ONLY *ONE* OF THE FOLLOWING:

PLEASE INDICATE WHICH ONE YOU WOULD LIKE ASSISTANCE WITH AND PROVIDE A MOST RECENT COPY OF YOUR LEASE, MORTGAGE STATEMENT OR BILL.

☐ **RENT/MORTGAGE/PROPERTY MANAGEMENT FEES**

☐ **MEDICAL EXPENSES**

☐ **UTILITIES**

☐ **PROPERTY TAXES**

NURSES HOUSE WILL NOT REVIEW ANY REQUESTS UNTIL *ALL* OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- ☐ **APPLICATION**
- ☐ **HEALTH STATUS REPORT COMPLETED BY YOUR HEALTHCARE PROVIDER**
- ☐ **PHOTOCOPY OF CURRENT NURSING LICENSE OR REGISTRATION**
- ☐ **PHOTOCOPY OF MOST RECENT W-2 OR DISABILITY INCOME REPORT**
- ☐ **PHOTOCOPY OF CURRENT MORTGAGE, LEASE STATEMENT OR MEDICAL BILL(S)**

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

______________________________________	____/____/______
Signature of Applicant	**Date**