

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): _____ Child Support Full Time Student

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

<u>MONTHLY INCOME</u>	<u>YOURSELF</u>	<u>SPOUSE/PARTNER</u>	<u>OTHER HOUSEHOLD MEMBER(S)</u>
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	_____	_____	_____

<u>OTHER RESOURCES SOUGHT</u>	<u>Date Filed</u>	<u>Response Date</u>	<u>If denied – reason</u> <u>If approved – amount and dates</u>
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	_____	_____	_____

<u>MONTHLY LIVING EXPENSES</u>	<u>Monthly Amount</u>	<u>Current? Y or N</u>	<u># of Months Behind</u>	<u>Amount in Arrears</u>
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(S).

RENT, MORTGAGE or 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 FOR ALL INDIVIDUALS OVER THE AGE OF 18 LIVING IN THE HOUSEHOLD.

PHOTOCOPY OF CURRENT LEASE, MORTGAGE STATEMENT OR MEDICAL BILL(S)

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

Signature of Applicant

____/____/____
Date

Each applicant must meet the following criteria for his/her profile to be considered for a grant. If an individual has not complied with the Nurses House application procedure, or the applicant does not meet the following criteria, the Executive Director has the authority to deny the applicant's request.

BASIC ELIGIBILITY REQUIREMENTS:

Applicant must have held an active registered nursing license in the United States or its territories.

Applicant must have held a position of employment within the past 36 months or be receiving short or long term disability, Social Security Disability, Social Security Income or worker's compensation.

Applicant's monthly income shall not exceed his/her basic and other necessary monthly expenses. In the event income exceeds basic and other necessary monthly expenses, consideration shall be given for extenuating circumstances.

Applicant must have sought assistance from at least two other resources prior to applying for NH assistance, including: short term or long term disability, Social Security Disability, worker's compensation, public assistance, food stamps, or help from family members or friends, church, or community groups.

Applicant must demonstrate a need for financial assistance due to illness, disability or other life crisis.

For applicants who meet the eligibility criteria, Nurses House will provide a grant to assist with one of the following:

Housing

Rent, Mortgage or Property Management Fees

NH assists in paying rent, mortgage or property management fees if applicant will be incapacitated for some time and will have limited income in that period.

Utilities

NH assists in paying for utilities (gas, electricity) in a case where he/she has no monthly rent or mortgage payment and no property management fees.

Property Taxes

NH assists in paying property taxes for guests who have no monthly mortgage and who reside in the home the property taxes are on.

Medical Expenses

NH assists in paying for medical expenses including health insurance premiums, medical bills and prescription medications.