Nurses House
The Veronica M. Driscoll Center for Nursing
2113 Western Avenue, Suite 2
Guilderland, NY 12084-9559
(518) 456-7858 ext. 128
mail@nurseshouse.org

Please PRINT CLEARLY!
Thank you.

APPLICATION FOR COVID-19 EMERGENCY ASSISTANCE

In response to the COVID-19 crisis Nurses House has established a fund and will be expediting all applications from nurses who are ill with COVID-19, who are caring for a family member with COVID-19, or who are under employer mandated quarantine due to COVID-19. This will be in effect through July 31, 2020.

Each applicant must meet the following criteria for his/her profile to be considered for a one time 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 nursing license in the United States or its territories.

Applicant must demonstrate a need for financial assistance due to diagnosis of COVID-19 for themselves or an immediate family member whom they are providing care for or be under a work mandatory quarantine.

Applicant must provide proof from a health care provider of a positive COVID-19 diagnosis for themselves or an immediate family member whom they are providing care for or a letter/email from employer stating the inability to work due to COVID-19 diagnosis or quarantine.

Ms. __ Miss. __ Mrs. __ Mr. __ Dr. __

NAME: _____
Last First Middle

ADDRESS: _____
Street City State Zip Code

TELEPHONE #: (_____) _____-_____ ALTERNATE #: (_____) _____-_____

E-MAIL ADDRESS:_____

DATE OF BIRTH: _____/_____/_____ LICENCE HELD (please circle): RN LPN/LVN

LICENSE #*: _____ STATE: _____ EXPIRATION DATE: ____/____/_____

SOCIAL SECURITY NUMBER*: _____-_____-_____

**This information is required to complete the application process. Privacy and security of confidential information shall be protected at all times, both during and after participation in the Nurses House grant program.*

HOW DID YOU HEAR ABOUT NURSES HOUSE? _____

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

If yes: Date: ____/____/_____ Name: _____

WERE YOU APPROVED? Y____ N____

If yes: Grant amount: $_____. _____ Number of Payments Received: _____

WHY ARE YOU APPLYING?

You are ill due to COVID-19_____ A family member is ill with COVID-19 _____

You are quarantined due to exposure to COVID-19 _____

HOUSING ARRANGEMENTS:

Homeless/Shelter _____ Live in another's dwelling _____

Live in own mortgaged dwelling _____ Live in own rented dwelling _____

MARITAL STATUS: S ___ M ___ Sep ___ D ___ W ___

LIST ALL MEMBERS OF THE HOUSEHOLD:			**Employed**	**F/T Student**	**Child Support**
Age	Gender	Relationship	Y or N	Y or N	Y or N
Age	Gender	Relationship	Y or N	Y or N	Y or N
Age	Gender	Relationship	Y or N	Y or N	Y or N
Age	Gender	Relationship	Y or N	Y or N	Y or N
Age	Gender	Relationship	Y or N	Y or N	Y or N
Age	Gender	Relationship	Y or N	Y or N	Y or N

EMPLOYMENT STATUS:

Full Time _____ Part Time _____

Short Term/Temp Disabled _____ Long Term/Permanently Disabled _____

Retired_____ Unemployed_____

Place of employment: _____

Employment position: _____

Name of supervisor: _____ **Contact #: (_____)** _____-_____

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

Anticipated return to work date: ____/____/_____ Part Time ____ Full Time ____

Briefly summarize present inability to work and/or limitations upon returning to work:

_____

_____

_____

_____

MONTHLY INCOME*	Yourself	Domestic Partner/ Spouse	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; amounts 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 Arrears**	**Total Amount Owed**
Rent/Mortgage/ Property Fees	_____	_____	_____	_____
Second Mortgage/ Home Equity Loan	_____	_____	_____	_____
Groceries for #____ people	_____	_____	____X ___	_____X _____
Electricity	_____	_____	_____	_____
Heat	_____	_____	_____	_____
Telephone	_____	_____	_____	_____
Alimony	_____	_____	_____	_____
Child Care	_____	_____	_____	_____
Child Support	_____	_____	_____	_____
OTHER EXPENSES				
Health Insurance Premium	_____	_____	_____	_____
Medications	_____	_____	____X____	_____X_____
Medical Expenses	_____	_____	_____	_____
Auto Payment	_____	_____	_____	_____
Auto Insurance	_____	_____	_____	_____
Gas	_____	_____	____X____	_____X_____
Bus Fare/Other Transportation	_____	_____	____X____	_____X_____

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

No ____ Yes ____ Verbal ____ Written ____

If yes, date of eviction/foreclosure: _____/_____/_____

ADDITIONAL PERTINENT INFORMATION:

_____

_____

_____

_____

_____

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

☐ **COMPLETED APPLICATION**

☐ **MOST RECENT PAY STUB**

☐ **DOCUMENTATION OF A POSITIVE COVID-19 DIAGNOSIS FOR YOURSELF OR AN IMMEDIATE FAMILY MEMBER 'OR' DOCUMENTATION PROVIDED BY YOUR EMPLOYER STATING YOUR INABILITY TO WORK DUE TO MANDATORY QUARANTINE**

*****ADDITIONAL DOCUMENTATION MAY BE REQUESTED AT ANY TIME AT THE DISCRETION OF NURSES HOUSE*****

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

_____ ____/____/_____

Signature of Applicant **Date**

For more information or to donate to Nurses House, please visit our website at www.nurseshouse.org