

Wellsprings of Florida Benevolence Fund Application for Financial Assistance

Date prepared _____

If you feel led to apply for benevolence, do so and let Wellsprings determine what might be available.

Note: To assure your application will be considered, please fully answer all questions. Our desire is to offer financial assistance to students of Christian Science who are expecting and working for spiritual healing and have limited sources to pay for Christian Science nursing care. The information presented will be held in strictest confidence and will be verified. This application must be signed by the applicant or person submitting the application for the applicant, **and** by the facility administrator or nurse providing services. The financial data on the reverse side must be completed for the application to be processed. Each request is handled on an individual basis. The information provided will help determine the amount of assistance required.

General Information about the Applicant (please print)

Name _____

Mother Church Member

Address _____

Branch Church or Society Member of

City _____ State _____ Zip _____

Telephone _____

Is a Journal-listed Christian Science Practitioner working for you?

Are you a resident in Florida?

Please give two references (not family members) who are members of The Mother Church, and who are acquainted with your life and work as a Christian Scientist

Name _____

Telephone _____

Name _____

Telephone _____

Financial Assistance

How much are you able to pay of your monthly care costs? \$ _____

How long can you make these payments? _____

Are family members able to assist with these costs?

If so, how much? \$ _____

Are you able to receive assistance from your Christian Science Association?

If so, how much? \$ _____

Are you able to receive assistance from your Church or Society?

If so, how much? \$ _____

Are you aware of possible assistance from The Dominion Fund?

How much assistance are you requesting? _____

(Please complete reverse side for additional financial data)

Accredited Christian Science facility or home care *Journal*-listed Christian Science nurse information

Name of facility or nurse providing care _____ Telephone _____

Address _____

Name of person submitting this application (if not patient) _____ Telephone _____

Relationship to patient _____ Date _____ Signature _____

To be completed by the facility or nurse providing home care

Applicant's level of care _____ Total monthly cost \$ _____

What portion of total monthly cost is attributable to nursing? _____

Is the facility depending upon Medicare for this patient? *(applicable only to CS nursing facility care)*

In the judgment of the facility or nurse, is patient radically relying on Christian Science?

Signature of facility administrator or nurse _____ Date _____

FINANCIAL INFORMATION

Assets and Liabilities

Assets

Checking accounts \$ _____
Savings accounts \$ _____
Securities (market value) \$ _____
Residence (market value) \$ _____
Other assets (property) \$ _____
Insurance, etc. \$ _____
Total assets _____

Liabilities

Unpaid bills- list \$ _____
\$ _____
\$ _____
Mortgage \$ _____
Other Loans \$ _____
Unpaid CS nursing exp \$ _____
Total Liabilities _____

Sources of Monthly Income and/or Receipts

Insurance that may help with your care \$ _____
Pension income \$ _____
Social security \$ _____
Spouse income, pension and Social Security \$ _____
Other income \$ _____ (Please describe) _____
Other assistance (Churches, C. S. Associations etc.) \$ _____ Frequency of Payments _____

Summary of Monthly Expenses

Household \$ _____ (Please describe)

Insurance expense – care \$ _____
Care Expenses \$ _____ (Percentage related directly to nursing care) ____%
Anticipated CS nursing costs \$ _____
Other Expenses \$ _____
Please Describe

Other Information - Is there any other information which you believe will be of benefit to evaluate this application?

Completed Application

The facility or nurse providing home care should forward the completed and signed application to:
Wellsprings of Florida
P. O. Box 40687
St. Petersburg, FL 33743-0687