Wellsprings of Florida Benevolence Fund
Application for Financial Assistance

Date prepared _____

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 very limited sources to pay for Christian Science nursing care. The information presented will be held in strictest confidence and will be verified. We share grant information with other Christian Science granting organizations. 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 ____ Yes ____ No

Address _____ Branch Church or Society Member of

City _____ State _____ Zip_____ _____

Telephone (___) _____

Is a Journal-listed Christian Science Practitioner working for you? __ Yes __ No Telephone (___) _____

How long have you resided in Florida? _____

Are you or have you been a Journal-listed Christian Science Practitioner?___ Journal-listed Christian Science Nurse? ___

How many years? _____

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? _____

How much assistance are you requesting? _____

(Please provide additional financial data on next page.)

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

Name of facility or nurse providing care _____ Telephone (___)_____

Address _____

Date when nursing care commenced, or entered CS facility _____

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

Relationship to patient _____ Date _____ Signature_____

Email to send correspondence relating to this application _____

To be completed by the facility or Christian Science 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? ____Yes ____ No (applicable only to CS nursing facility care)

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

Signature of facility administrator or nurse _____ Date_____

FINANCIAL INFORMATION

Assets and Liabilities

Assets		**Liabilities**	
Checking accounts	$_____	Unpaid bills· list	$_____
Savings accounts	$_____		$_____
Securities (market value)	$_____		$_____
Residence (market value)	$_____	Mortgage	$_____
Other assets (property)	$_____	Other Loans	$_____
Insurance, etc.	$_____		
Total assets	$_____	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) ____%

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 Christian Science nurse providing home care should forward the completed and signed application to:

Wellsprings of Florida
P. O. Box 40687
St. Petersburg, FL 33743-0687