



Internal Use Only

\_\_\_ PD \_\_\_ AL \_\_\_ OD \_\_\_ DM

**APPLICATION FOR ASSISTANCE**

Name of Applicant: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Apartment Name: \_\_\_\_\_ Birthdate (M/D/Y): \_\_\_\_\_  
Apartment Address: \_\_\_\_\_ Apartment Number: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Applicant's Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**Please select what services you need:      Dental Care /      Vision /      Hearing Aids**

<b>Income</b>	<i>Monthly</i>	<b>Assets</b>	<i>Total Value</i>
Social Security	\$ _____	House	\$ _____
Pensions, IRA's Etc.	\$ _____	Other Property	\$ _____
Trusts, Others	\$ _____	Life Insurance	\$ _____
Veteran's Admin.	\$ _____	Investments	\$ _____
Family	\$ _____	Savings	\$ _____
Working Wages	\$ _____	Money Owed to Me	\$ _____
Other: _____	\$ _____	Other: _____	\$ _____
<b>Total Income:</b>	<b>\$ _____</b>	<b>Total Assets:</b>	<b>\$ _____</b>

<b>Expenses</b>	<i>Monthly</i>
Facility Rent	\$ _____
Food	\$ _____
Transportation	\$ _____
Utilities	\$ _____
Medications	\$ _____
Other	\$ _____
<b>Total Expenses:</b>	<b>\$ _____</b>

**Please Select Your Type of Housing**

\_\_\_ Long-term Care/Assisted Living

*Apartments:*

\_\_\_ HUD \_\_\_ Seniors \_\_\_ All Ages

*House:*

\_\_\_ Own \_\_\_ Family \_\_\_ Rent

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If the senior is unable to sign for themself:*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

**Please mail application to 721 North Main St #106, Layton, UT 84041 or email to [info@seniorcharitycare.org](mailto:info@seniorcharitycare.org)**

## Demographic Questions

Print Name: \_\_\_\_\_

Q. What is your sex?  Male  Female  Transgender  Binary  Prefer Not to Say

Q. Do you have transportation?  None  Self  Family  Transportation Company

Q. What is your marital status?  Married  Single  Divorced  Widowed

Spouse (If Married): \_\_\_\_\_

Q. Are you a veteran?  Yes  No

Q. What is the highest degree or level of school you have completed?

- Did not complete High School
- High school graduate - high school diploma or the equivalent (GED)
- Bachelor's degree (for example: BA, AB, BS) or higher
- Unreported or Unknown

Q. Do you have any dental insurance?  Yes  No *If "Yes" Please list:* \_\_\_\_\_

Q. Do you have Medicaid?  Yes Medicaid Number \_\_\_\_\_  No

Q. Do you have Medicare?  Yes  No

Q. Do you have a disability?  Yes  No *If yes, please check type below:*

- Ambulatory Difficulty
- Cognitive Difficulty
- Hearing Difficulty
- Independent Living Difficulty
- Self-Care Difficulty
- Vision Difficulty
- Other:

Q. What is your ethnicity or race? Please check all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White/Caucasian
- Two or more races
- Unreported or Unknown

Q. What is your primary language?

English  Spanish  French  German  Chinese  Other: \_\_\_\_\_