****

**Disciples Senior Assistance Program**

(for ages 62+)

APPLICATION FOR MONTHLY STIPEND

*Please print or type all information*

**APPLICANT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Applicant |  | Birthdate  |  |

 (MM/DD/YYYY)

**Residential address of Applicant**

|  |  |
| --- | --- |
| Street |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

**Mailing address if different than residential address above**

|  |  |
| --- | --- |
| Street or PO Box |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

**Applicant’s congregational membership**

|  |  |
| --- | --- |
| Name of Your Church |  |

|  |  |
| --- | --- |
| Senior Pastor Name |  |

|  |  |
| --- | --- |
| Street |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

**Information of person filling out application, if different from Applicant**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |

|  |  |
| --- | --- |
| Street or PO Box |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

**Designated Party who is responsible to represent Applicant** *(There is no financial responsibility for the Applicant)*

(i.e., Relative, Person with Power of Attorney, Guardian who is in regular contact with the Applicant.)

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |

|  |  |
| --- | --- |
| Street or PO Box |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

**DEMONSTRATION OF FINANCIAL NEED**

**Applicant’s Use of Available Resources to Manage Living Expenses**

Applicants are encouraged to make use of available community resources for support. Check the box if the Applicant has connected with any agency to assist in obtaining available financial resources.

|  |  |  |
| --- | --- | --- |
|[ ]  Area Agency on Aging | Contact Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone |  | Email |  |

|  |
| --- |
|[ ]  Health Insurance Counseling and Advocacy Program (HICAP) |

|  |  |
| --- | --- |
| Contact Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone |  | Email |  |

|  |  |  |
| --- | --- | --- |
|[ ]  Veteran Administration (VA) |  |  |

|  |  |
| --- | --- |
| Contact Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone |  | Email |  |

|  |  |  |
| --- | --- | --- |
|[ ]  Other | Agency Name |  |

|  |  |
| --- | --- |
| Contact Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone |  | Email |  |

What alternatives, if any, have you implemented or explored to reduce your living costs? Is there more that you can do?

|  |
| --- |
|  |

**Information On Parties Contributing to Your Financial Support**

|  |  |
| --- | --- |
| Has your family been asked to contribute towards your financial support? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |

|  |  |
| --- | --- |
| Street or PO Box |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Support Amount  | $ | Frequency (Monthly, Annually, Other) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Relationship |  |

|  |  |
| --- | --- |
| Street or PO Box |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Support Amount  | $ | Frequency (Monthly, Annually, Other) |  |

**APPLICANT’S FINANCIAL DETAIL**

|  |  |  |
| --- | --- | --- |
| ASSETS |  | LIABILITIES |

**Cash Loan Balances**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Checking Accounts | $ |  | Home Mortgage |  | $ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Savings Accounts/CDs | $ |  | Home Equity Loan |  | $ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Investment Securities Account | $ |  | Other: |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cash value Life Insurance/Annuity | $ |  |  |  | $ |

**Value of Real Property** **Credit Cards**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Home | $ |  |  |  | $ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Other property | $ |  |  |  | $ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Automobile | $ |  |  |  | $ |

**Other** **Other**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | $ |  |  |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **TOTAL ASSETS** |  | $ |  | **TOTAL LIABILITIES** |  | $ |

|  |  |  |
| --- | --- | --- |
| MONTHLY INCOME |  | MONTHLY EXPENSES |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Social Security/SSA |  | $ |  | **Housing** |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Supplemental Security/SSI |  | $ |  | Mortgage/Rent/Fee |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Specialized Secondary/SSP |  | $ |  | Utilities/Phone/Cable |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pension/401 |  | $ |  | Property Taxes |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| IRA |  | $ |  | **Insurance** |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Investment Income/Interest |  | $ |  | Medical |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Family Assistance |  | $ |  | Automobile |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Other** (list) |  |  |  | Home or Rental |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | $ |  | **Medical** |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | $ |  | Office Visits/Treatment |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | $ |  | Prescriptions |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **TOTAL MONTHLY INCOME** |  | $ |  | Dental Care |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Eye Care |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Over the Counter |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Personal Expenses** |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Food |  | $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Household Supplies |  | $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Recreation/Entertain |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Transportation/Gas |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Note for Monthly Expenses:****Prorate any annual, semi-annual, and quarterly expenses to a monthly equivalent.* |  |  |  | Pet Care |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Church Tithe/Offering |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | $ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **TOTAL MONTHLY EXPENSES** |  | $ |

**CONGREGATIONAL REFERENCE INFORMATION**

Please provide the contact information for the two persons who will be submitting reference forms for the Applicant. *See reference forms for instructions.*

|  |  |
| --- | --- |
| Pastor Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

|  |  |
| --- | --- |
| Name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

**STIPEND REQUEST**

|  |  |
| --- | --- |
| Requested amount per month *(up to $700.00 per month)* | $ |

**Third Party Payee Information for Stipend Payment**

(i.e., landlord, residential facility, service provider, Responsible Party)

|  |  |
| --- | --- |
| Provider or Agency Name |  |

|  |  |
| --- | --- |
| Contact Name |  |

|  |  |
| --- | --- |
| Street or PO Box |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

**APPLICATION SUBMITTAL CHECK LIST**

🗹 Application Form

 ✓ Applicant Information (Page 1)

 ✓ Resource Utilization (Page 2)

 ✓ Financial Detail (Page 3)

 ✓ Stipend Request (Page 4)

🗹 Copy of most recent income tax return, or documentation of tax exemption, if available. (Attach)

🖂 Reference Form to be submitted by Pastor

🖂 Reference Form to be submitted by another member of the congregation

SUBMIT APPLICATION OR REFERENCE FORMS TO:

OAMC OR scan/PDF and email to OAMC@docpswr.org

Christian Church (DOC) PSWR

115 E. Wilshire Avenue

Fullerton, CA 92832



**Disciples Senior Assistance Program**

(for ages 62+)

CONGREGATIONAL REFERENCE FOR MONTHLY STIPEND

*Please print or type all information*

**APPLICANT TO COMPLETE THIS SECTION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Applicant |  | Date  |  |

 (MM/DD/YYYY)

I waive the right to review reference submittals for the Disciples Senior Assistance Program.

|  |  |
| --- | --- |
| Signature of Applicant |  |

**PASTOR TO COMPLETE THIS SECTION AND SUBMIT FORM DIRECTLY TO OAMC**

|  |  |
| --- | --- |
| Pastor Name |  |

|  |  |
| --- | --- |
| Street |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

Describe the Applicant’s congregational participation and need for financial assistance.

|  |  |
| --- | --- |
| Signature of Pastor |  |

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(for ages 62+)

CONGREGATIONAL REFERENCE FOR MONTHLY STIPEND

*Please print or type all information*

**APPLICANT TO COMPLETE THIS SECTION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Applicant |  | Date  |  |

 (MM/DD/YYYY)

I waive the right to review reference submittals for the Disciples Senior Assistance Program.

|  |  |
| --- | --- |
| Signature of Applicant |  |

**CONGREGATIONAL MEMBER TO COMPLETE THIS SECTION AND SUBMIT FORM DIRECTLY TO OAMC**

|  |  |
| --- | --- |
| Name |  |

|  |  |
| --- | --- |
| Street |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City |  | State |  | Zip |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone | ( ) | Email |  |

Describe the Applicant’s congregational participation and need for financial assistance.

|  |  |
| --- | --- |
| Signature of Congregational Member |  |

SUBMIT REEFERENCE TO:

OAMC OR scan/PDF and email to OAMC@docpswr.org

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Fullerton, CA 92832