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**ADULT DAY SERVICE CENTER**

**Participant's Financial Disclosure Form**

Scholarship Partner

# Participant's Name: Age \_\_\_\_\_\_

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

Primary Care Giver:

Address if different\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone 1) 2) 3) \_

**Individual Monthly Income\*:**

Amount

|  |  |
| --- | --- |
| Social Security (Income or Disability): |  |
| Aid and Assist V.A. Benefits: |  |
| Defined Benefit Pension Plan: |  |
| Investment Income (Stocks, bonds, rental, Dividends, Interest, Capital Gains): |  |
| Monthly income from Settlement(s): |  |
| IRA Distribution : |  |
| Railroad Retirement Benefits: |  |
| Any Other Income (Sub-S, LLC-Part ner): |  |
| Amount Family willing to pay to help sustain Scholarship Fund (per Day): |  |

\*Please attach a copy of the most recent Federal Income Tax return for the Participant. If tax form not filed or available then a copy Social Security Benefits and Bank Statement needs to be pro vided .

**Please answer the following:**

If St. Agnes wasn't available, what is your Alternative for Care (home health, nursing, etc.)? How important is financial assistance to you?

If Scholarship is not an option, how would you pay for daily cost (by what means)?

What impact does St. Agnes have on you as the caregiver (I.e. allow you to work, shop, relax etc.)? Would your loved one come more days if Scholarship is approved?



Office Use Only:

Client Cost Share (Based on above information)

St. Agnes Scholarship Share \_