



ADULT DAY SERVICE CENTER

Participant's Financial Disclosure Form

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):	
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-Partner):	
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 provided.

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?

Signature (Caregiver/POA) *Date*

Office Use Only:

Client Cost Share (Based on above information) _____ St. Agnes Scholarship Share _____