2017 Grant Application

For more information:

Call: 941-328-8088

Email: info@scsac.net

www.SCSAC.net

Applicant Information:

Name: _____ Date of Birth: _____

Address: _____ ( ) _____
Street City Zip Telephone

Email address (if available):_____

Emergency Contact 1: _____ Phone: _____

Emergency Contact 2: _____ Phone: _____

Type of Assistance Requested:

_____ **Personal Emergency Response Systems:**
(Commonly known as "Fall Buttons")
Briefly Describe Medical Condition: _____
_____

Medical documentation from your doctor, physical therapist, occupational therapist or other health care professional is required for consideration.

_____ **Durable Medical Equipment:**
(For Medical Equipment not covered by Medicare, Medicaid or Private Insurance)

Briefly describe Medical Condition & Equipment Needed: _____
_____

Primary Doctor: _____ Phone: _____

Medical documentation from a physician, therapist or other health care professional is required for consideration. Please include a copy of your Medicare, Medicaid and/or insurance card.

_____ **Emergency Assistance:** Briefly describe the circumstances that require immediate assistance.
_____
_____
_____
_____
_____

General Guidelines for Eligibility:

Household Size	Annual Income	Monthly Income
1	$17,820	$1485
2	$24,030	$2003

Applicant's Total Monthly Income: $_____

- Please provide proof of all income including: Social Security Statements, Pensions, Annuities, VA Pensions, etc.
- **Total Assets** including savings accounts, annuities, mutual funds, stocks, bonds etc. $_____

_____ Are you currently enrolled in the Community Care for the Elderly Program? (CCE)

_____ Are you a Veteran? If Yes, did you serve during War time? _____

_____ Are you enrolled in Medicaid? If yes, please include a copy of your Medicaid Card.

_____ Are you enrolled in Medicaid Long Term Managed Care? If yes, who is your provider and case manager? _____

I understand the maximum grant award is limited to $400 in goods or services this year.
I understand that I must be a Sarasota County resident aged 50 or older and meet the stated income requirements.

I certify that the above information is true and the disclosure of income is accurate.

_____ **Date:** _____
Applicant Signature

Return application to:
Sarasota County Senior Advocacy Council
5020 Clark Road, Suite 414
Sarasota, FL 34233

Or

Scan completed form and email to: president@scsac.net

Visit us at:
www.SCSAC.net