Grant Application

For more information:
Call: 941-328-8088
Email: info@scsac.net
www.SCSAC.net

Applicant Information:

Name:____ DOB: __________________

Address:____ (   ) __________________
Street City Zip Telephone

Email address (if available):____

Emergency Contact 1:________________________________Phone: ___________________________

Emergency Contact 2:________________________________Phone: ___________________________

Type of Assistance Requested:

Note: *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.***

Primary Doctor:__________________________ Phone: ________________________________

______ **Personal Emergency Response Systems:**
(Commonly known as "Fall Button")
Briefly Describe Medical Condition: ____

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______ **Durable Medical Equipment, Dental, or Vision Assistance:**
(For medical equipment or services not covered by Medicare, Medicaid or Private Insurance)
Briefly describe medical condition & equipment needed: ______________________________

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

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Eligibility Requirements: Income and Assets

Household Size	Annual Income Not to Exceed	Monthly Income Not to Exceed	Liquid Assets Not to Exceed
1	$24,280	$2,023	$6,069
2	$32,920	$2,743	$8,229

A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE (800-435-7352) WITHIN THE STATE. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THE STATE. REGISTRATION NUMBER # CH49122.

Applicant's total monthly income: $__________________________
Please provide proof of all income including: Bank Statement, Social Security Statements, Pensions, Annuities, VA Pensions, etc. – Grant application will not be considered until financial information is received

Total Liquid 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 that this application is valid for 90 days. All documentation must be submitted for consideration. If all documentation is not submitted within 90 days from the date on application, it will be denied, and a new one must be submitted for consideration.

I understand the maximum grant award is limited to $500 in goods or services per calendar year and is paid to the service provider, not the applicant.

I understand that I must be a Sarasota County resident aged 50 or older and meet the stated income requirements.

I understand that the Sarasota County Senior Advocacy Council may disclose my personal information to third parties for services rendered or payment information.

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

____ **Date:**______________________
Applicant Signature

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

Or

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

For Grant Committee Use Only

Date Recvd		$ Reqstd		Decision		Assigned to		Outcome		Date Complete

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