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: ____
____

_____ **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: ______________________________
____

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

Eligibility Requirements:

Household Size	Annual Income Not to Exceed	Monthly Income Not to Exceed
1	$24,280	$2,023
2	$32,920	$2,743

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 $500 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 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: president@scsac.net

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