

WESTMINSTER RETIREMENT COMMUNITIES OF FLORIDA

To apply for a Grant, please submit the completed application to:

Westminster Retirement Communities
 Attn: Suzanne Ujcic, Grant Coordinator
 80 West Lucerne Circle
 Orlando, Florida 32801

For more information call 407-839-5050 or 1-800-948-1881, ext. 226

CONFIDENTIAL FINANCIAL DISCLOSURE

(You may be required to produce financial records to support the following information)

GENERAL INFORMATION Medicare No. _____

Full Name _____ Social Security No. _____

Mailing Address _____

City _____ State _____ Zip Code _____ Telephone _____

Date of Birth _____ Marital Status: Single Married Widow(er)

Name of Spouse _____ Date of Birth _____

SERVICE HISTORY: To assist our Foundation in determining eligibility, please complete the following service record. This record should include only the service of applicant or spouse of applicant employed on a full time basis in any of the following capacities:

- Minister Missionary Church Educator Surviving Spouse

CHURCH, AGENCY, LOCATION and TELEPHONE NUMBER	FROM	TO

Total Years of Service: _____

FINANCIAL INFORMATION: In order to maintain the financial security of our residents and the organization, please list below your total assets, liabilities, and annual income. All prospective grant applicants are required to complete this information so we may evaluate the most appropriate grants for you. If applicant is married, please include income and assets of spouse.

ASSETS	DESCRIPTION	APPLICANT	CO-APPLICANT
	Checking	\$ _____	\$ _____
	Savings	\$ _____	\$ _____
	C. D.'s	\$ _____	\$ _____
	Stocks & Bonds	\$ _____	\$ _____
	Real Estate	\$ _____	\$ _____
	Other	\$ _____	\$ _____
	Total:	\$ _____	\$ _____
	Combined total:	_____	= \$ _____

WESTMINSTER RETIREMENT COMMUNITIES OF FLORIDA

APPLICANT: _____

ANNUAL INCOME	DESCRIPTION	APPLICANT	CO-APPLICANT
	Social Security	\$ _____	\$ _____
	Pension	\$ _____	\$ _____
	C. D. Income	\$ _____	\$ _____
	Investment Income	\$ _____	\$ _____
	Interest from Savings	\$ _____	\$ _____
	Other Pensions/annuities	\$ _____	\$ _____
	Other	\$ _____	\$ _____
	Total:	\$ _____	\$ _____
	Combined total:		= \$ _____

DEBTS OWED	Owed	Monthly
Hospital	\$ _____	\$ _____
Doctor	\$ _____	\$ _____
Dental	\$ _____	\$ _____
Personal	\$ _____	\$ _____
Credit Cards	\$ _____	\$ _____
Pharmacy	\$ _____	\$ _____
Other	\$ _____	\$ _____
	Total:	\$ _____

ARE ANY DEBTS OWED TO YOU (please list) Yes No

_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

I hereby certify that this financial statement is a true report of my/our assets, income and indebtedness.

Date: _____ Applicant: _____

Date: _____ Co-Applicant _____

Reviewed by: _____	
Recommended Grant(s):	Entrance Fee \$ _____ Other _____
Approved by: _____	Date: _____