

**ROTARY COMMUNITY CORPS OF
ADULT DAY HEALTH PROGRAM, INC.
(RCCADHP)
NEW ENGLAND SINAI HOSPITAL'S SCHOLARSHIP FUND**

Fact Sheet

Purpose: The Rotary Community Corps of Adult Day Health Program, Inc. offers financial support for individuals to attend the New England Sinai Hospital Adult Day Health Program. To qualify for consideration for assistance, candidates must not be able to pay for the program due to financial constraints and must not be eligible for financial support from other sources. Scholarship funds will be awarded for individuals and will be used exclusively to attend the program. By supporting a frail adult family member, scholarship funds also assist with providing “respite” time for caregivers and allow the much needed opportunity to replenish their energies through personal pursuits, health care, and family or social activities.

Financial guidelines are adjusted annually in accordance with federal guidelines. The RCCADHP scholarship committee will determine eligibility.

Eligibility: Any individual who resides in the service area of New England Sinai Hospital is eligible for consideration. Eligibility is based on the medical, social, financial, and physical needs of the individual and the primary caregiver.

Commitment: Recipients of scholarship funds are asked to make a good faith effort to fulfill the attendance requirements related to the assistance being granted.

Funding: Funding for the Adult Day Health Care Program (medical model) Scholarship, and the Parkinson's Adult Day Health Care Program Scholarship, is made possible due to the commitment of the RCCADHP, and contributions from Rotary clubs, individuals, businesses, organizations, and foundations.

Contributions & Donations: Tax-deductible contributions should be made payable to the RCCADHP and are to be forwarded to Deb Ribak, Social Worker and Admissions Coordinator of Adult Day Health Services, New England Sinai Hospital, 150 York Street, Stoughton, MA 02072.

Information: For information regarding making a gift or eligibility, please contact Deb Ribak at the New England Sinai Hospital at (781) 297-1375.

**RCCADHP of New England Sinai Hospital
SCHOLARSHIP APPLICATION**

Name of Applicant _____

Applicant's Address _____

Name of Caregiver _____

Caregiver's Address _____

Caregiver's Telephone Number _____

Caregiver's Relationship to Patient _____

Explain the home situation and care demands:

Is the need immediate? _____

Explain: _____

How did you hear about this program? _____

Return this form and "Confidential Financial Statement" to Deborah Ribak, New England Sinai Hospital, 150 York Street, Stoughton, MA 02072. If you have any questions, please call Deb at 781-297-1375.

RCCADHCP
Scholarship Application
New England Sinai Hospital
150 York Street
Stoughton, Massachusetts 02072-9105
ATT: Deborah Ribak

CONFIDENTIAL FINANCIAL STATEMENT

Participant Name _____
Marital Status _____
Guarantor's Name _____
Relationship to Participant _____
Address _____
City/State/Zip _____
Phone _____
Number in family that resides at above address: _____

Below information is based on participant and spouse:

Assets:

Savings	\$ _____
Checking	_____
Building or second home	_____
Stocks & Bonds Securities	_____
IRA or Annuity	_____
Cash on hand	_____
Motor Vehicle	_____
Other Assets (specify)	_____
Total Assets	

Gross Monthly Income:

Social Security Income	\$ _____
Veterans Benefits	_____
SSI	_____
Dividends/Interest	_____
Trusts or Annuity payments	_____
Spouse's Income	_____
Other Income	_____
Total Monthly Income (A)	\$ _____

Employer Name and Address:

**RCCADHP
Scholarship Application**

Monthly Expenses:

Rent or Mortgage	\$ _____
Insurance Payments	_____
House	_____
Car	_____
Life	_____
Medical	_____
Average Utilities	_____
Electricity	_____
Gas/Oil	_____
Telephone	_____
Food	_____
Child Care (if appropriate)	_____
Medical Bills/Prescriptions	_____
Other (specify)	_____
Total Expenses (B)	\$ _____

Total Income (A from prior page) - Total Expenses (B from above) = Net Monthly Income
\$ _____ - \$ _____ = \$ _____

Health Coverage:

Name _____ ID# _____

The undersigned certifies that the information given above is complete and correct to the best of his/her knowledge. The undersigned agrees to supply documentation to support or verify the information provided above.

I authorize New England Sinai Hospital & Rehabilitation Center to obtain verification of the above data from the sources named. Copies: Any person may rely upon a copy of this instrument, certified before a Notary Public to be a true copy, to the same extent as the original.

I authorize the New England Sinai Hospital & Rehabilitation Center to release any information required in the course of my treatment as necessary and requested by any regulatory agency in conformance with applicable regulations.

Please check one (1): I am enclosing a copy of my latest federal tax return.
 I am not required to file a federal tax return.

Date _____ Signature _____