

# NEW ENGLAND SINAI HOSPITAL'S ALZHEIMER'S ADULT DAY HEALTH SCHOLARSHIP

## Fact Sheet

**Purpose:** The Alzheimer's Scholarship Fund offers financial support for individuals to attend the Alzheimer's Adult Day Health Program. Qualifying families are those who have family members that have Alzheimer's Disease. This scholarship enables and encourages caregivers to seek help from professionals who have been trained in Alzheimer's care. The resulting "respite" time provides caregivers the much needed opportunity to replenish their energies through personal pursuits, health care, and family or social activities.

Financial guidelines are adjusted annually. Eligibility will be determined by the Rotary Community Corps of Adult Day Health Program (RCCADHP) committee and will be adjusted in accordance with federal guidelines. The Scholarship program offers financial support for individuals to attend the Alzheimer's Day Center for as long as they remain qualified for care.

**Eligibility:** Any family which includes a person with Alzheimer's Disease or a related disorder who resides in the service area of New England Sinai Hospital and Rehabilitation Center is eligible for consideration. Funding is based on financial, social and physical needs of the person with Alzheimer's Disease and their primary caregiver.

**Commitment:** The caregiver is asked to make a good faith effort to fulfill the attendance requirements of the assistance being granted.

**Funding:** Funding for scholarships is made possible by the Sinai Men's Associates, generous contributions from individuals, the Sinai Employee Fund, businesses and foundations.

**Contributions & Donations:** Tax-deductible contributions can be made to the scholarship endowment fund or to directly sponsor an upcoming scholarship. Checks should be made payable to New England Sinai Hospital and sent to: The Sinai Foundation, New England Sinai Hospital, 150 York Street, Stoughton, MA 02072. For further information about making a gift, call the Foundation Director Bettyann McKenzie at (781) 297-1328.

**Information:** For information regarding the scholarship, please call Deb Ribak, Social Worker and Admissions Coordinator of Adult Day Health at the New England Sinai Hospital, at (781) 297-1375.

**ALZHEIMER'S 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.

**Alzheimer's 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:

\_\_\_\_\_  
\_\_\_\_\_

## Alzheimer's 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 \_\_\_\_\_