APPLICATION
CARE AND ASSISTANCE PROGRAM
BLET NATIONAL AUXILIARY

TO: The BLET National Auxiliary

We hereby submit the following application for your consideration:

Name of Applicant: _____

Address: _____
(Street Address, City, State, Zip)

Phone No. _____ Date of Birth: _____

Initiated into Auxiliary No. _____ City _____ State ____ Initiation Date: _____

Is membership continuous? _____ If not, please explain: _____
_____

Sponsor's Name: _____ Sponsor's Aux. No. _____

Widowed: _____ If yes, how long? _____ Number of Children: _____ Ages: _____

Applicant's Income Information

Total Monthly Income: $_____ (Social Security/Railroad Retirement/Interest/Dividends, etc.)

Do your children contribute to your support? _____ If yes, how much? $_____

Is Applicant living in own home _____ Apartment _____ Child's Home _____

Nursing Home _____ If yes, is this temporary _____ Monthly cost $_____

Is Applicant capable of supervising personal financial affairs? _____ If not, please advise who holds a Power of Attorney, and provide the following information: Name: _____

Relationship: _____ Street Address: _____ City _____

State _____ Zip _____ Phone Number: _____

Insurance

Does Applicant have
Health insurance _____ Medicare _____ Medicaid _____

If Medicare, do you have a Medicare Supplement policy _____
Monthly Cost $_____
Incidental Medical Costs (please itemize medications/medical costs not covered by insurance and the appropriate monthly total below – attach additional sheet if needed):
_____

_____

Approximate Monthly Total for Incidental Medical Costs: $_____

Comments Concerning this Application
(If more room needed, please attach additional sheet)

_____

_____

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_____

_____

_____

We hereby certify the foregoing information to be true and correct. We consider this application to be in compliance with the Bylaws of the BLET Auxiliary.

Date of Application: _____

Auxiliary No. _____

President: _____
Printed Name:_____

Secretary: _____
Printed Name:_____

Note to Auxiliary President and Secretary:

This form is to be completed by you from information secured from the Applicant or her family. It will be used to evaluate the needs of your Applicant.

It is the policy of the Auxiliary that Care and Assistance Program checks will not be mailed to nursing or convalescent homes. Please fill in the form completely, and mail to:

Auxiliary Seal

Jodi Wallace, National Secretary
BLET Auxiliary
1804 Washington Ave
La Grande, OR 97850