Internal Use Only
___PD ___AL ___OD ___DM
___Pres A/E:_____

APPLICATION FOR ASSISTANCE

Name of Applicant: _____

Apartment Name: _____
if applicable

Address: _____
including unit #

City, State, Zip: _____

Today's Date: _____

Birthdate (M/D/Y): _____

Applicant's Phone: _____

I can receive texts (scheduling) ☐ YES

Email: _____

Please **select** what services you need: ☐**Dental Care** / ☐**Vision** / ☐**Hearing Aids**



Monthly Income *Monthly*

Social Security (Net)..... $ _____

Working Wages..... $ _____

Family Gifts/Contributions..... $ _____

Other (explain)..... $ _____
Pensions, IRA, VA, Trusts, Royalities, ETC

Total Income **$** _____

Please Select Your Type of Housing

_☐_ Long-term Care/Assisted Living

Apartments:
_☐_ HUD _☐_ Seniors _☐_All Ages

House:
_☐_ Own _☐_ Family _☐_ Rent

Expenses
Facility Rent $ _____

Assests
Savings $ _____

Signature: _____ **Date**: _____

If the senior is unable to sign for themself- You must provide your contact information below.

Select all that apply. The following person:

☐ *Client Advocate / Proxy* ☐ *Emergency Contact*
☐ *Contact for SCHEDULING* ☐ *Help with Language Translation*
☐ *Ok to release information to this person*

Name: _____ Relationship: _____

Phone Number: _____ Email (optional): _____

Please mail application to 721 North Main St #106, Layton, UT 84041
or emal to: Info@SeniorCharityCare.org

Note: Correspondence address ONLY. Clinic locations vary throughout the state.
Call if you need assistance 801-515-0480

Demographic Questions

Print Name: _____

Q. What is your sex? ☐ Male ☐ Female ☐ Perfer not to say ☐ Other_____

Q. Do you have transportation? ☐ No ☐ Self ☐ Family ☐ Transportation Company

Note: We understand that traveling isn't always possible; however, being able to attend clinics in other areas could help you get the services you need more quickly.

Q. I am willing to travel to any of the following valley areas: ☐ Salt Lake ☐ Tooele ☐ Ogden ☐ Provo

Q. What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse (Name): _____

Q. Are you a veteran? ☐ No ☐ Yes - THANK YOU!

Q. What is the highest degree or level of school you have completed?

- ☐ Did not complete High School
- ☐ High School Graduate or GED
- ☐ Associates Degree or Trade School
- ☐ Bachelor's Degree or Higher
- ☐ Unreported or Unknown

Q. Do you have any dental insurance? ☐ No ☐ Yes *If "Yes" Please list:* _____

Q. Do you have Medicaid? ☐ No ☐ Yes - Medicaid Number_____

Q. Do you have Medicare? ☐ No ☐ Yes - Standard ☐ Yes - Medicare Health Advantage

Q. Do you have a disability? ☐ No ☐ Yes - *If yes, please check type below:*

- ☐ Ambulatory Difficulty
- ☐ Independent Living Difficulty
- ☐ Other: _____
- ☐ Cognitive Difficulty
- ☐ Self-Care Difficulty
- ☐ Hearing Difficulty
- ☐ Vision Difficulty

Q.What is your ethnicity or race? Please check all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Two or more races
- ☐ Unreported or Unknown

Q.What is your primary language?

☐ English ☐ Spanish ☐ Other: _____

Note: If primary language is NOT English, please provide contact information on opposite side for translator.

Health History

Print Name: _____

Street Address: _____

City: _____ **State :** _____ **Zip:** _____

Date of Birth: _____ **Age:** _____

Allergies:

- ☐ None
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Codeine
- ☐ Sulfa
- ☐ Penicillin
- ☐ Metal: _____
- ☐ Other: _____

Conditions:

- ☐ Alcohol Use
- ☐ Anemia
- ☐ Anxiety/Nervousness
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Join Replacement
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding- Abnormally
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Bruises Easily
- ☐ Cancer/Tumors
- ☐ IV Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cough- Persistent
- ☐ Chest Pain / Angina
- ☐ Dementia / Alzheimer's
- ☐ Diabetes
- ☐ Dialysis
- ☐ Drug Addiction
- ☐ Endocarditis (Heart Infection)
- ☐ Epilepsy / Seizures
- ☐ Edema
- ☐ Eye Problems
- ☐ Fainting / Dizziness
- ☐ Gastrointestinal Problems
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pacemaker / Defibrillator
- ☐ Heart Surgery
- ☐ Hepatitis (A, B, C, D, E)
- ☐ Herpes / Cold Sores / Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Organ Transplant
- ☐ Osteonecrosis of Jaw
- ☐ Osteoporosis Treatment
- ☐ Lung Problems
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Sinus Issues
- ☐ Steroid Treatments
- ☐ Stroke / TIA
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tuberculosis

Other health conditions, diseases, or surgeries (please list):

_____

_____

_____

Medications

Please list medication name and what it is for- ex: high blood pressure.

_____

_____

_____

_____

_____

_____

Dental

Do you currently have dentures? ☐ No ☐ Yes

If yes mark all that apply: ☐ Top ☐ Bottom ☐ Partial

Are you wearing your dentures? ☐ Yes ☐ No. Why?_____

How old is your denture? (approximately) _____

About how many natural teeth do you have? Top: _____ Bottom: _____

Vision

When was your last eye exam? (approximately) _____

What kind of eyewear do you currently use (check *all* that apply)?..... ☐ None- N/A

☐ Single Vision Distance ☐ Lined bifocals or Trifocals ☐ Computer Glasses
☐ Single Vision Near ☐ No-line / Progressive Lenses ☐ Contact Lenses

Are you experiencing any of the following?..... ☐ None- N/A

☐ Blurred Vision ☐ Eye Pain ☐ Dry Eyes
☐ Double Vision ☐ Itching ☐ Watery Eyes
☐ Light Sensitivity ☐ Buring ☐ Discharge
☐ Eye Fatigue / Strain ☐ Floaters ☐ Other: _____

Please select the condition if either yourself or a close relative has been diagnosed with..... ☐ None- N/A

Myself: ☐ Macular Degeneration ☐ Glaucoma ☐ Blindness

Relative: ☐ Macular Degeneration ☐ Glaucoma ☐ Blindness

Any other eye disease:_____

I have filled out this medical history form accurately and to the best of my knowledge. I understand that providing incorrect or inaccurate information can put me at risk for potential problems regarding my treatment. It is my responsibility, and I agree, to inform Senior Charity Care of any changes in my medical status.

Patient (or Responsible Party) Signature: _____ **Date**: _____