THE LADY CUBITT COMPASSIONATE ASSOCIATION

Founded by Lady Cubitt 1932 - Incorporated 1945

APPLICANT INFORMATION FORM

For office use only:
Patient Name :
Patient ID: LCCA _ _ _ _ _ _ _
Activation Date :

PERSONAL INFORMATION

APPLICANT (Circle one): Dr. Miss Mr. Mrs. Ms.

FIRST MIDDLE LAST SUFFIX

ADDRESS

RESIDENCE

MAIL

HOME CONTACT TELEPHONE _____ CELL PHONE _____
EMAIL _____

DATE OF BIRTH _____
(dd / mm / yy)

HEALTH (Circle one): Good Average Poor

STATUS (Circle one): Unknown Divorced Married Separated Single Widow(er)
NAME OF SPOUSE _____
SPOUSE WORKPLACE _____

LIST DEPENDENTS YES / NO

NAMES: FIRST LAST AGE SEX OCCUPATION

EMPLOYER'S DETAILS

EMPLOYER NAME _____ YRS SERVICE _____
POSITION _____

ADDRESS

RESIDENCE

MAIL

WORK CONTACT TELEPHONE _____ CELL PHONE _____
EMAIL _____

PREVIOUS EMPLOYMENT NAME _____ YRS SERVICE _____
POSITION _____

NAME _____ YRS SERVICE _____
POSITION _____

NAME _____ YRS SERVICE _____
POSITION _____

FINANCIAL INFORMATION

APPLICANT HAS APPLIED TO SOCIAL SERVICES

(Circle one)
Pending
Yes
No

Social Worker / Results : _____

If not, why not? (Use "NONE" if appropriate)

_____

_____

APPLICANT HAS APPLIED TO OTHER SOURCES FOR ASSISTANCE

(Circle one)
Pending
Yes
No

Organization / Results : _____

If not, why not? (Use "NONE" if appropriate)

_____

_____

WHO SUGGESTED THAT YOU APPLY TO THE LCCA FOR ASSISTANCE _____

OWNS RESIDENCE YES / NO
OWNS CAR YES / NO
HAS OTHER DEBT YES / NO
If yes, please describe debts

_____

_____

OWNS OTHER PROPERTY YES / NO
ANY LOANS/MORTGAGE YES / NO
If yes, provide brief list

_____

_____

TOTAL INCOME (Monthly)

_____

_____

_____

_____

_____

_____

_____

_____

TOTAL EXPENSES (Monthly)

_____

_____

_____

_____

_____

_____

_____

_____

GIVE PARTICULARS OF ANY PERTINENT INFORMATION

_____

_____

_____

_____

I hereby certify that the particulars given on both sides of this form are correct.
I further recognize that if any statements given are falsified, that this will constitute fraud.
I authorize the release of information from Social Services Department or any other Agency to enable LCCA to make justified evaluation of my application.

_____
(Signature)

_____
(Print Name)

_____
Date

ACTION TAKEN BY LCCA

_____

_____

_____

_____

Created: March, 2003