

THE BRYANT DENT FOUNDATION, INC.
45286 F. Birch Lane
California, Maryland 20619

APPLICATION FOR BENEFITS
Once completed, mail to the address above

1. Personal Information

a. Client making application (for communication purposes)

Name: _____ SS# _____

Address: _____ Birth date: _____

_____ Telephone: (w) _____

(h) _____

(c) _____

b. Person for whom benefit is being requested (if different from above)

Name: _____ SS# _____

Address: _____ Birth date: _____

_____ Telephone: _____

c. Spouse of Person for whom benefit is being requested (if different from #1)

Name: _____ SS# _____

Address: _____ Birth date: _____

_____ Telephone: (w) _____

(h) _____

(c) _____

d. Other Family Members (include children and siblings of person for whom benefit is being requested)

Name: _____ Address: _____ Relationship _____ SS# _____

_____ Telephone: (w) _____ (h) _____

Name: _____ Address: _____ Relationship _____ SS# _____

Telephone: (w) _____ (h) _____

Name: _____ Address: _____ Relationship _____ SS# _____

Telephone: (w) _____ (h) _____

Name: _____ Address: _____ Relationship _____ SS# _____

Telephone: (w) _____ (h) _____

- e. Are there any disabled (as defined by Social Security) Children, Grandchildren, or other Family Members? No _____ Yes _____
If so please state their name, age, and relationship _____

2. Health Care Facility Information of Person Seeking Benefits

If applicable please provide the following:

Date of Admission: _____ Contact Person: _____

Name and address of facility _____

Health Care Facility Costs: Daily Rate _____

Average Monthly Supplemental Charges _____

If the person for whom benefits are being sought is not in a health care facility then what are the current care arrangements and costs? _____

3. Medical Insurance

- a. Do you have Medicare? Yes _____ No _____

b. Do you have other insurance or Medicare Supplement? Yes___ No___ if yes please list name of company or type of policy and average cost of premium _____

c. Do you have Medicaid? Yes _____ No _____

d. Does the spouse of the applicant have insurance, if so state type and average cost of premiums _____

e. Does the applicant have any Long-Term Care Insurance

Name of Company _____

Cost \$ _____

4. Is the applicant a Veteran? Yes _____ No _____

a. Honorably discharged? Yes _____ No _____

b. If there is a service related percentage of disability rating, please describe: _____

5. Health Status of person seeking benefits

Describe primary injury and how it occurred and when it occurred (include what vertebrae are damaged and whether complete or incomplete)

Describe any other health problems: _____

Describe Medications: _____

List any and all doctors that are currently providing treatment, (include name, address, and phone number)

6. Describe the type of benefit you are seeking

Indicate specific equipment, specific financial needs, specific vocational needs, or any other needed benefit:

7. Financial Facts

a. Income: Non Asset Based (Social Security, pension, annuity)

Please describe the income of the person(s) for whom benefits are being sought and if applicable, the spouse's income. If the income is directly deposited to a bank by Social Security, Pension, etc. please indicate.

Source	Payable to Whom	Amount	Frequency	Bank	Direct Deposit (y/n)

b. Income Generated from Assets:

Source	Payable to Whom	Amount	Frequency	Bank	Direct Deposit (y/n)

c. Housing Expenses:

Please list the costs associated with your principle residence:

- Rent / Mortgage \$ _____/month
- Real Estate Taxes \$ _____/ year
- Homeowner’s Insurance \$ _____/year
- Gas/Electric \$ _____/month
- Heating Oil \$ _____/year
- Other Heating Source \$ _____/year
- Condo Fee \$ _____/month
- Water and/or Sewer \$ _____/month
- Ground Rents \$ _____/year

d. Real Estate: If the applicant or the applicants spouse own additional real estate please indicate:

Address	Name(s) on Deed	Assessed Value	Fair Market Value (best estimate)

e. Burial Arrangements

List whether the applicant or the applicants spouse have a pre-arranged funeral (the cost and location) and whether either on cemetery plots or crypts (state place, value, and how titled)

f. Automobiles and Recreation Vehicles (including boats, RV's, ATV's, etc)

Make Model Year	Name of Owner	Current Fair Market Value

g. Life Insurance (if the applicant or the applicants spouse have a life insurance policy please complete below)

Life Ins. Co.	Owners of Policy	Original Face Value	Cash Value	Dividend Additions	Dividend Accumulations	Loan on Policy	Beneficiary

h. Securities (Stocks, Bonds, Mutual Funds):

Name of Security and Number of Shares	Owner(s)	Value per Share

i. Tax Deferred Assets (Ira Accounts, 401k, Keogh, Tax Deferred Annuities, etc):

Type of Account	Owner(s)	Value	Beneficiary

j. Trusts: Is the applicant or the applicant's spouse the beneficiary of a trust, if yes explain?

Yes _____ No _____

k. Bank Accounts: please list all accounts including money market, certificates of deposit, checking, and or savings:

Bank	Type of Account	Name on Account	Amount

l. Debts: if you or spouse owe any large bills or have any outstanding loans or mortgages, please indicate below:

Creditor	Name(s) of Debtor	Principle Balance

m. Miscellaneous

Other than household goods, clothing, and jewelry, and those items previously listed in this application, do you or your spouse own anything else of value? Please list.

n. Gifts and Transfers of Assets:

Have you or your spouse given away or transferred any money or property to another person within the past 3 months? (or 60 months if given away from a trust)

Yes _____ No _____ If yes please indicate:

Date	Amount	To Whom

8. Legal Documents:

Please indicate which of the following legal documents the applicant or the applicants spouse already have, and be prepared to provide copies.

- a. Last Will and Testament: Yes _____ No _____
- b. Durable Financial Power of Attorney: Yes _____ No _____
- c. Advanced Medical Directive for the State of Maryland: Yes _____ No _____
- d. Living Will if not part of AMD for the State of Maryland: Yes _____ No _____
- e. Deeds: Yes _____ No _____
- f. Trusts: Yes _____ No _____

Date this form is completed _____

Name of person completing this form _____

Please let us know how you found us or anything else that you would consider important in our decision making process. _____
