

Application for Financial Assistance

Mission:Dignity

Please complete all pages of this form and sign it in blue or black ink, then return it to:

Dept. of Financial Assistance
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498

APPLICANT INFORMATION

Name: _____ Social Security number: _____

Gender: Male Female Birth date: ____/____/____ Daytime telephone: (____) _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

If you would like your mail to go to someone else, provide the following:

Name: _____ Daytime telephone: (____) _____

Mailing address: _____

City: _____ State: _____ ZIP Code: _____

Your health status: Good Fair Poor Disabled

LIVING SITUATION

- | | | |
|--|---|--|
| <input type="checkbox"/> House (own) | <input type="checkbox"/> Mobile home | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> House (buying) | <input type="checkbox"/> Apartment | <input type="checkbox"/> With relative |
| <input type="checkbox"/> House (renting) | <input type="checkbox"/> Apartment (rent based on income) | <input type="checkbox"/> Assisted living |
| <input type="checkbox"/> House (HUD) | <input type="checkbox"/> Other: _____ | |

STATUS INFORMATION

Marital status: Married Widowed Single Divorced

Number of living children: _____ Number of dependents: _____

SPOUSE INFORMATION

Spouse name: _____ Social Security number: _____

Spouse birth date: ____/____/____ Date of marriage: ____/____/____

Date of: Spouse's death: ____/____/____ Divorce: ____/____/____

Spouse health status: Good Fair Poor Disabled

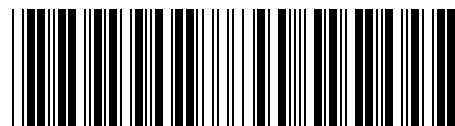
PAID SOUTHERN BAPTIST SERVICE (FIRST-TIME APPLICANTS ONLY)

Total years of salaried service: _____ Names of states/international country served: _____

Capacity in which you or your spouse served (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Pastor | <input type="checkbox"/> Church administrator | <input type="checkbox"/> Seminary staff |
| <input type="checkbox"/> Associate pastor | <input type="checkbox"/> Director of Missions | <input type="checkbox"/> State convention staff |
| <input type="checkbox"/> Minister of music | <input type="checkbox"/> Missionary | <input type="checkbox"/> Children's home staff |
| <input type="checkbox"/> Minister of education | <input type="checkbox"/> Board/commission staff | <input type="checkbox"/> Other: _____ |

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INCOME-BASED ASSISTANCE

Do you or your spouse receive any of the following income-based assistance (not including Mission:Dignity):

- Medicaid assistance with medical or drug plan costs
- Medicaid assistance with nursing home costs
- Medicare Part D at reduced or no cost
- Social Security pays your Medicare premium (Amount is not deducted from your check.)
- Drug company assistance with prescription drug costs
- Supplemental Security Income
- HUD-financed housing
- Assistance with rent
- Assistance with utilities
- Food stamps \$ _____
- Other: _____

If you checked one of the above boxes, will receiving a monthly check from the Mission:Dignity program reduce or eliminate that assistance? Yes No

Is your Medicare premium deducted from your Social Security check? Yes No

ESTIMATED MONTHLY INCOME

| | You | Spouse |
|------------------------------------|----------|----------|
| GuideStone retirement benefit | \$ _____ | \$ _____ |
| Social Security | \$ _____ | \$ _____ |
| Supplemental Security Income (SSI) | \$ _____ | \$ _____ |
| Veterans benefit | \$ _____ | \$ _____ |
| Interest income | \$ _____ | \$ _____ |
| Salary | \$ _____ | \$ _____ |
| Other pension plans | \$ _____ | \$ _____ |
| Other: _____ | \$ _____ | \$ _____ |
| Total | \$ _____ | \$ _____ |

ESTIMATED MONTHLY EXPENSES

| | |
|--|----------|
| Mortgage, rent or room and board | \$ _____ |
| Utilities (combined total of gas, electric, telephone, water, etc.) | \$ _____ |
| Prescription drug bills (out-of-pocket costs not covered by insurance) | \$ _____ |
| Medical bills (out-of-pocket costs not covered by insurance) | \$ _____ |
| Food and household items | \$ _____ |
| Car payment | \$ _____ |
| Car expense (gas, maintenance, etc.) | \$ _____ |
| Automobile insurance premium | \$ _____ |
| Burial insurance premium | \$ _____ |
| Homeowner's insurance premium | \$ _____ |
| Life insurance premium | \$ _____ |
| Medical insurance premium | \$ _____ |
| Other insurance premium | \$ _____ |
| Tithe | \$ _____ |
| Other expenses | \$ _____ |
| Property tax on home | \$ _____ |
| Total | \$ _____ |

ASSETS

Please indicate an amount even if it is zero (\$0.00).

Real estate (other than home) \$ _____

Checking account balance \$ _____

Savings account balance \$ _____

Certificates of Deposit (CDs) \$ _____

Other investments \$ _____ (including stocks, bonds, etc.)

ADDITIONAL INFORMATION

Please tell us about any specific needs or give additional information concerning your situation.

APPLICANT SIGNATURE (SIGN BELOW)

Signature: _____ Date: ____/____/____

If the applicant has granted Power of Attorney allowing someone else to act on his or her behalf, send a copy of the documentation with this application, unless you have already given a copy to GuideStone.

PRAYER MINISTRY

The Mission:Dignity ministry provides prayer cards to donors that have the names of recipients who've given permission to share their information. Would you allow us to share your and your spouse's name (if applicable), address and birth date (month and day only) on a prayer card with donors of the program? Yes No

ALTERNATE CONTACT PERSON

Please provide the name of a relative or friend we can contact if we are unable to reach you.

Contact name: _____ Relationship: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Home telephone: (_____) _____ Work telephone: (_____) _____

GUIDESTONE USE ONLY

New applicant

Pend for trustee review in: February July November

By: _____ Date: ____/____/____ Letter

Approve **Effective date:** ____/____/____

Monthly Months: _____ Amount: \$ _____

Expense Months: _____ Amount: \$ _____ Reason: _____

Louisiana Shepherd's Fund: \$50 \$65

One-time grant Amount: \$ _____

Decline/terminate **Effective date:** ____/____/____

Terminate: Monthly Expense Other: _____

Decline

Reason: Income Assets Age Years of service

Other: _____

Processed by: _____ Date: ____/____/____ Letter