GRANT APPLICATION SUZANNE JACOBSON MEMORIAL FUND

Date of Submission ____________________________

Have you applied for SJMF funds within the last year? If so when? ____________________________

Name ________________________ Age _________

Address ____________________________________

City ________________ State ____ Zip __________

Phone ______________________________________

Doctor's Name ______________________________

Medical Diagnosis ___________________________

Is the medical diagnosis a life-threatening illness? ______________________

Treatment Location __________________________

Number of adults in the household and relationship to the applicant ___________________

____

____

Number of children in the household and relationship to the applicant ___________________

____

____________________ Ages __________________

ASSETS

Do you have money in the following:

Checking Account	$________________
Savings Account	$________________
Stocks/Bonds/Investments (value)	$________________
Real Estate (value)	$________________
Automobile(s) (value)	$________________
Other Assets	$________________
Total Assets	$________________

By submitting and signing this application, the applicant or representative of the applicant, guarantees its accuracy and truth with the intent that it is relied upon by the SJMF Committee in considering assistance to the undersigned.

The applicant/applicant representative signature also serves as a release of information should additional information be needed by representatives of the Prairie Lakes Healthcare Foundation.

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Applicant or Applicant Representative Signature

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Applicant Representative's Relationship to the Applicant

____

Date

Return completed applications to:
Prairie Lakes Healthcare Foundation
401 9th Ave NW
Watertown, SD 57201

SUZANNE JACOBSON MEMORIAL FUND

PRAIRIE LAKES
Healthcare Foundation

MONTHLY INCOME

Employer Name ____________________

Spouse's Employer Name ____________________

Applicant Income/Social Security $____________________

Spouse Income/Social Security $____________________

State Government Benefits $____________________

Food Stamps/SNAP/WIC $____________________

Retirement Income $____________________

Veteran's Benefits $____________________

Child Support $____________________

Alimony $____________________

Other Income $____________________

Total Monthly Income $____________________

ESTIMATED MONTHLY EXPENSES

Rent/Mortgage $____________________

Food/Groceries $____________________

Credit Card Payment $____________________

Car Payment(s) $____________________

Car Insurance $____________________

Gas/Electricity/Water/ $____________________
Waste Disposal/Heating/Sewage

Phone (Landline/Cell) $____________________

Internet/Cable/Streaming $____________________

Gas/Transportation $____________________

Doctor/Hospital Payments $____________________

Applicant/Spouse/
Dependent(s) Medication $____________________

Medical Insurance $____________________

Life/Homeowner's Insurance $____________________

Childcare $____________________

Child Support $____________________

Taxes/Property Taxes $____________________

Loans $____________________

Household Expenses $____________________
(i.e. toiletries, clothing, cleaning supplies, etc.)

Other Expenses $____________________

Total Monthly Expenses $____________________

If you receive this grant, please check below where the funds are needed most, the amount requested, and the name and address of the entity the funds should be paid to.

❏ Medications $__________ (amount requested)

Pharmacy name & address ____________________

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❏ Gas $__________ (amount requested)

Gas station name & address ____________________

____

____

❏ Groceries $__________ (amount requested)

Grocery store name & address ____________________

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❏ Utilities (Gas/Electricity/Water/Waste Disposal/
Heating/Sewage) $__________ (amount requested)
(please break out if necessary)

Please list the name of company/companies &
addresses ____________________

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❏ Rent/Mortgage $__________ (amount requested)

Name & Address of entity to be paid ____________________

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