



CUPHSONAA, INC.

THE COLUMBIA UNIVERSITY-PRESBYTERIAN HOSPITAL
SCHOOL OF NURSING ALUMNI ASSOCIATION, INC.

480 MAMARONECK AVENUE

HARRISON, NY 10528

TEL: (914) 481-5787

FAX: (914) 481-5788

MONTHLY STIPEND APPLICATION

ELIGIBILITY REQUIREMENTS: THE APPLICANT MUST BE AT LEAST 65 YEARS OLD AND DEMONSTRATE FINANCIAL NEED. THE MAXIMUM ANNUAL INCOME LIMIT IS \$25,000 FOR A SINGLE PERSON AND \$30,000 FOR A COUPLE. ALL APPLICANTS FOR BENEFITS MUST BE DUES-PAYING MEMBERS OF OUR ASSOCIATION FOR THE PAST 5 CONSECUTIVE YEARS. IF THE MEMBERSHIP REQUIREMENTS ARE NOT MET, THE APPLICANT IS REQUIRED TO PAY BACK DUES FOR THE PAST 5 YEARS AS LONG AS THE APPLICATION IS ACCEPTED AND THE BENEFIT IS TO BE AWARDED. IF THIS REQUIREMENT HAS NOT BEEN MET BUT THERE IS A CLEAR CASE OF NEED, ASSISTANCE WITH MEMBERSHIP REQUIREMENTS WILL BE CONSIDERED.

NAME:			
CLASS OF:			
ADDRESS:			
TELEPHONE(S):	(H)	(C)	(W)
E-MAIL:			
PLEASE COMPLETE THE ENTIRE APPLICATION BELOW.			
MARITAL STATUS:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW(ER)		
DEPENDENTS AND THEIR AGES:	1. 2. 3.		
NAME AND ADDRESS OF FAMILY/FRIEND AND PHONE WHOM WE MAY CONTACT IF NEEDED:			
EMPLOYMENT STATUS:			
PRESENT EMPLOYER:			

STATUS:	<input type="checkbox"/> ACTIVE <input type="checkbox"/> PART-TIME <input type="checkbox"/> SEMI-RETIRED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED
INCOME: (PER MONTH)	
EMPLOYMENT:	\$
DIVIDENDS:	\$
ANNUITIES:	\$
INTEREST:	\$
SOCIAL SECURITY:	\$
PENSION:	\$
OTHER RETIREMENT INCOME: PLEASE SPECIFY	\$
EXPENSES: (TOTAL COST PER MONTH)	
A. HEALTH INSURANCE PREMIUMS: (SELF)	
MEDICARE:	\$
HEALTH INSURANCE CO-PAYMEN	\$
DENTAL:	\$
MEDICATIONS:	\$
OTHER:	\$
B. DEPENDENTS: (PLEASE LIST AND GIVE THE NATURE OF THEIR DEPENDENCY AND NON-REIMBURSABLE COSTS ASSOCIATED WITH THEIR CARE) AN IRS1040 IS REQUIRED DOCUMENTATION	
DEPENDENT #1	
DEPENDENT #2	
DEPENDENT #3	
C. HOUSING: PLEASE ATTACH (1) COPY OF LAST YEAR'S 1040 INCOME TAX FORM IF REQUIRED BY THE IRS FOR REVIEW BY THE FINANCE COMMITTEE AND (2) THE OTHER PERSON COMPLETING THIS FORM AND RELATIONSHIP TO APPLICANT	
DO YOU:	<input type="checkbox"/> OWN HOME <input type="checkbox"/> RENT <input type="checkbox"/> OTHER: SPECIFY
TOTAL COST PER MONTH: (RENT/MORTGAGE, UTILITIES, INSURANCE)	\$
LIVING EXPENSES: (FOOD, CLOTHING,	\$

TRANSPORTATION)

PLEASE DESCRIBE; USE ADDITIONAL PAGE IF NECESSARY

**** ARE YOU RECEIVING ANY ASSISTANCE FROM THE FEDERAL OR STATE SOURCES THAT COULD BE REDUCED BECAUSE OF THE GIFTS YOU RECEIVE FROM THE ALUMNI ASSOCIATION? CHECK ONE: YES NO**

PLEASE ATTACH

- 1) A COPY OF LAST YEAR'S 1040 INCOME TAX FORM (IF YOU FILE ONE) FOR REVIEW BY THE FINANCE COMMITTEE. THIS INFORMATION IS STRICTLY CONFIDENTIAL AND DOES NOT GO BEYOND THE FINANCE COMMITTEE WHO IS CHARGED WITH APPROVING THE STIPENDS.
- 2) PROOF OF AGE (PHOTOCOPY OF DRIVER'S LICENSE, PASSPORT, OR BIRTH CERTIFICATE)

YOUR SIGNATURE:

DATE:

OTHER PERSONS HELPING TO COMPLETE THIS FORM AND THEIR RELATIONSHIP TO APPLICANT:

NAME:

ADDRESS:

TELEPHONE:

E-MAIL ADDRESS:

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT US AT (914) 481-5787 OR BY EMAIL AT INFO@CUPHSONAA.ORG

YOU MAY FAX OR MAIL THIS APPLICATION. THANK YOU.

www.cuphsonaa.org