

Applicant Background Information

3. Date of Birth: _____ - _____ - _____

4. Type of Disability: ◆—————▶

- Mental Illness
 - Developmental Disability or Mental Retardation
 - Brain Injury/Spinal Cord Injury
 - Physical Disability (Must specify)
- _____

Verification of a disability must accompany the application if the applicant does not have an agency sponsor. Examples of acceptable documentation of a disability include but are not limited to: a statement or determination of disability on agency letterhead from the Veteran's Administration, the Division of Vocational Rehabilitation or a VR provider, a community support or psychiatric rehabilitation provider, a Regional Office for the Division of Developmental Disabilities, the local housing authority, private disability insurance or other human service organization.

5. Living Situation:

- Lives independently in own home or apartment
- Lives with family (biological, relatives or adoptive)
- Lives with foster family
- Lives in a supported living setting (< 24 hour supported care)
- Lives in a supervised living setting (24 hour supervised care)

6. If living in 24 hour supervised care, please describe more specifically:

- Staffed apartment
- Group home
- ISL (Individualized Supported Living)
- RCF (Residential Care Facility)
- Nursing home
- State-operated facility (specify) _____
- Other (specify) _____

7. Applicant receives the following public benefits: ◆—————▶

- SSI Per month \$ _____
 - SSDI Per month \$ _____
 - Food stamps
 - Medicaid
 - Medicare
 - Other benefits (specify)
- _____
- Applicant receives no public benefits

The applicant must provide proof of income. Examples of acceptable documentation of income include, but are not limited to a letter from the Social Security Administration listing benefits and amount, a copy of the applicant's social security check for the previous month or a copy of tax forms filed with the IRS for the previous year.

8. Household income: ◆—————◆

Number of persons in household: _____
 Gross annual income of household: \$ _____

9. Type of assistance requested:

- Medical and dental care and equipment
- Rehabilitation training, services or devices
- Supplemental education assistance
- Personal goods and services
- Transportation

Description of Request for Assistance

10. Briefly describe the specific item or service that is requested:

11. Describe the applicant’s situation. Include why the item or support requested in #10 above is needed and how it will benefit the recipient:

12. Amount Requested*: \$ _____

*An estimate or invoice from the vendor or other documentation of the cost of the item(s) requested must be enclosed. If the request is for dental care, a treatment plan **must** be enclosed.

Outside Resources

13. Has applicant applied for a grant through Midwest Special Needs Trust in the past?

- Yes
- No

14. Has an effort been made to secure funds for above request through other sources?

- Yes
- No

If yes, to whom (agency or resource) was the request made?

Was the request denied?

- Yes What was the reason for denial?: _____
- No

Please Sign Below

By signing below, I attest to the truth and accuracy of all information provided in this application. I understand that failure to provide accurate and complete information will result in denial of the request.

I certify by signing below that the applicant has a disability and that the income amounts shown on page 2, Item 7 are current, accurate and have been verified by me or other agency staff.

Applicant Signature

Date

Agent/Advocate Signature (If applicable)

Date