Charitable Grant Program Application

Return the application with required documents to:

Midwest Special Needs Trust
P.O. Box 7629
Columbia MO 65205
Email: grants@midwestspecialneedstrust.org
Phone: (573) 256-5055

ELIGIBILITY

1. You must be a Missouri resident
2. You must have a disability that is verified by the Social Security Administration
3. You must meet the income guidelines listed below. The yearly gross household income[1] cannot go over the following 2021 Federal Poverty Guidelines:

Persons in Household	Maximum Income	Persons in Household	Maximum Income
1	$12,880	5	$31,040
2	$17,420	6	$35,580
3	$21,960	7	$40,120
4	$26,500	8	$44,660

If you do not meet all of these qualifications, you are not eligible to apply for a grant.

****Please Note: Applicants who meet the qualifications are not guaranteed a grant. We have limited funds available each year. We strive to meet as many needs as possible, but we are unable to help with every request received.**

GRANT AMOUNT

The maximum grant amount is $1500. Grant decisions are based on the amount shown on the estimate or treatment plan. You may only receive one grant in a 12-month period of time.

TYPES OF GRANTS

General Grants: These funds are available to help with needs not covered by insurance, public benefits or available through other community programs.

Urgent Care Grants: These funds are available for urgent medical and dental needs which require more immediate intervention.

TYPES OF ASSISTANCE NOT PROVIDED

Grants will not be awarded for any need that is obtained before the grant is approved. The grant will not help with vehicle purchases, food, cash, rent or mortgage payments and household expenses such as taxes, insurance, utilities and moving.

GRANT AWARD PROCESS

General Grants are awarded by the Board of Trustees four times a year. Please refer to the chart below for deadlines, when your grant decision will be made, and when you will receive a letter in the mail from us.

Deadlines to send us your application	Grant decisions are made[2]	MSNT will send a letter with the grant approval or denial by
March 31	Early May[2]	May 31
June 30	Early August[2]	August 31
September 30	Early November[2]	November 30
December 31	Early February[2]	February 28

Urgent Grant awards are made twice each month. Applications for this grant may be submitted at any time.

Applicants and agency representatives will receive a letter in the mail after the review. ***Award decisions will not be shared over the phone.***

GRANT PAYMENTS

All grant payments are made by check. Payment will be made only to the business listed on MSNT's authorization form.

[1] Yearly Gross Income is the amount of money a household receives in one year before any deductions. This includes income from all sources.

[2] Board meeting dates are subject to change

Please keep this page for your records

Midwest Special Needs Trust

Charitable Grant Program Application

Return the application with required documentation to:

Midwest Special Needs Trust
P.O. Box 7629
Columbia MO 65205
Email: grants@midwestspecialneedstrust.org
Phone: (573) 256-5055

APPLICATION PROCESS

People who meet the qualifications listed on Page 1 need to complete an application. An agency representative, such as a case manager, social worker or other advocate, may assist in completing the application. An agency representative may also complete an application on behalf of their client. To be considered for a grant the application must be complete, accurate and sent with the following information:

*Proof of all gross income received by the applicant. This must include a current copy of the SSI and/or SSDI award letters from Social Security. This letter needs to state the monthly amount(s) they receive and show that they receive disability benefits. Proof of all wages, child support, retirement income, etc., must be sent as well.

*Proof of gross income for everyone else living in the home, no matter the age of the person or the relationship.

*An estimate. Estimates must be a letter from the business, separate from the application. The estimate must include a list of the items needed and the exact cost of each one. It also needs to include the name and contact information for the business. If the request is for dental needs, the estimate must be a treatment plan from a dental provider. If the request is for a modification to a home, the estimate must be from a licensed contractor and the applicant must provide proof of home ownership or a letter of approval from the landlord.

*For requests of medical equipment, exercise equipment, communication devices, lift chairs and monitoring systems, we need a letter of recommendation from a licensed professional. The letter needs to state why the item(s) are needed.

*For hearing aid and eyeglasses requests, you must also send a copy of the evaluation.

This application is for (check one)

☐ **General Charitable Grant**

☐ **Urgent Medical and Health Care Grant**

Contact Information

Date: _____

1. Applicant Information

_____
First Name **Last Name**

_____
Mailing Address **Apt/Lot #**

_____
City **State** **Zip Code**

_____
Phone Number

2. Agency Representative (Not Required)

_____
First Name **Last Name**

_____
Organization

_____
Mailing Address

_____
City **State** **Zip Code**

_____
Phone Number

_____
Email Address

Applicant Background Information

3. Date of Birth: _____-_____-_____

4. Type of Disability:

☐ Mental Illness
☐ Physical Disability (Must specify) _____
☐ Developmental Disability
☐ Brain Injury
☐ Spinal Cord Injury

5. Living Situation: (mark all that apply)

☐ Lives Alone ☐ Lives with Spouse ☐ Lives with Children ☐ Lives with Parents
☐ Lives with Foster Parents ☐ Lives with Other; Describe_____
☐ Staffed apartment or assisted living facility ☐ ISL (Individualized Supported Living)
☐ Group home or residential treatment facility ☐ RCF (Residential Care Facility)
☐ Nursing home
☐ State-operated facility (specify) _____
☐ Other (specify) _____

6. **Total number of people who live in the home:**_____

7. Applicant receives the following monthly income(s):

☐ Supplemental Security Income $_____
☐ Social Security Disability Insurance $_____
☐ Social Security Retirement Benefit $_____
☐ Other income: Type _____ $_____
Type _____ + $_____
Total Monthly Income = $_____

☐ Food Stamps
☐ Medicaid
☐ Medicare
☐ Applicant receives no public benefits or has no income

8. List everyone else that lives in the home. List their monthly income:

_____ $_____
_____ $_____
_____ $_____
_____ + $_____
Total Monthly Income = $_____

9. Total from #7 $_____+ #8 $_____= $_____x12= $_____ Total (Gross) Yearly Income

✶ Please refer to the 2021 Federal Poverty Guidelines chart below to see if you meet the income qualifications. If your annual ***gross*** income is over these guidelines you do not need to continue with the application process.

Persons in Household	Maximum Income	Persons in Household	Maximum Income
1	$12,880	5	$31,040
2	$17,420	6	$35,580
3	$21,960	7	$40,120
4	$26,500	8	$44,660

10. 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

11. List the specific item or service that is needed:

_____

12. Describe the applicant's situation. Include why the item or service requested above is needed and how it will benefit the applicant. Please provide as much information as possible:

_____

_____

_____

_____

13. Amount Requested: $_____ (Maximum Grant is $1,500)

Name of business you wish to use: _____
Address:_____
Phone Number:_____

14. If the estimate is greater than $1,500, how will the remainder of the bill be paid?

_____

Outside Resources

15. What effort has been made to find help with this need from other agencies?

_____

Was the request denied? ☐ Yes ☐ No

What was the reason for denial? _____

Please Sign Below

By signing below, I attest to the truth and accuracy of all information provided in this application. I understand failure to provide accurate and complete information will result in denial of the request. I also understand I am not guaranteed a grant.

_____ _____
Applicant Signature **Date**

I certify by signing below that I have assisted the applicant to complete the application, and that the information provided is accurate. I understand failure to provide accurate and complete information will result in denial of the request. I also understand the applicant is not guaranteed a grant.

_____ _____
Agency Representative Signature (If applicable) **Date**

Application Completion

Before sending in the application include **ALL** of the following documents. If you have questions about the items listed below please refer to Page 2 of the application or call our office.

☐ Copy of the applicants Social Security Award Letter(s)
☐ Proof of income for everyone living in the home
☐ Completed 4 Page Application (Keep Page 1 for your records)
☐ Proof of all income applicant receives
☐ Estimate or Treatment Plan

Please refer to Page 2 of the application to see if any of the following items are needed:

☐ Letter of Recommendation ☐ Proof of Home Ownership ☐ Copy of Evaluation

How did you hear about our Charitable Grant Program? _____