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

Eligibility

-Applicants must be a Missouri resident, have a Social Security verifiable disability, and meet income guidelines.

-**Applicants are not guaranteed a grant.**

-Grants may be requested for medical and dental care, rehabilitative services or equipment, safety equipment, communication devices, assistive technology, educational assistance, specialized transportation and other needs not covered by insurance, public benefits or available through other community programs.

-Individuals may receive only one grant in a 12 month period.

-Grants cannot be given to those who have a Special Needs Trust with MSNT or any other trust company.

-Grant awards will *NOT* be awarded for goods purchased or services performed prior to grant award, vehicle purchases, food, rent/mortgage payments, taxes, and housing expenses such as insurance and utilities.

All applications must be submitted with:

-Proof of ***all*** household income. **Annual gross household income** must not exceed the 2019 Federal Poverty Guidelines. (Poverty Guidelines chart located on Page 2)

-A ***current*** copy of SSI and/or SSDI award letters providing monthly income(s) and proving disability.

-An estimate or a current treatment plan from a vendor showing cost of the service or item(s) requested. Estimates must be on the providers letterhead and include an itemized list and the exact cost of each item as well as the name and contact information for the provider. Home modification estimates must be from a licensed contractor, and applicant must provide proof of home ownership or letter of approval from landlord.

-For all medical equipment, exercise equipment, communication devices, lift chairs and monitoring system requests, a letter of recommendation from a licensed professional stating why the item(s) are needed must accompany application.

-Hearing aid and eye glasses requests need to include a copy of the evaluation.

This application is for (check one)

☐ **General Charitable Grant**-Grants are awarded by the Board of Trustees on a quarterly basis. Applications must be received by 4:30 pm on or before the following deadline dates: March 31, June 30, September 30 and December 31. ***Award decisions are made approximately 5 weeks after each deadline.***

☐ **Urgent Medical and Health Care Grant**- This grant is available *only* for urgent medical and dental needs which require immediate intervention. Applications are accepted on an ongoing basis. Grant awards are made twice per month.

All applicants and agency representatives will receive written notice of approval or denial of the application.

Contact Information

Date: _____

1. Applicant Information

_____
First Name **Last Name**

_____
Street Address

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

_____
Phone Number

2. Agency Representative (If applicable)

_____
First Name **Last Name**

_____
Organization

_____
Street 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_____
☐ Lives in a supported living setting (< 24 hour supported care)
☐ Lives in a supervised living setting (24 hour supervised care)

Total number of persons in household:_____

6. ***If*** living in 24 hour supervised care, please specify:

☐ Staffed apartment or assisted living facility
☐ Group home or residential treatment facility
☐ Nursing home
☐ ISL (Individualized Supported Living)
☐ RCF (Residential Care Facility)
☐ State-operated facility (specify) _____
☐ Other (specify) _____

7. Applicant receives the following ***gross*** monthly income:

☐ 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 all other household members and their ***gross*** monthly income:

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

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

Please refer to the 2019 Federal Poverty Guidelines chart below to see if you meet income guidelines. If your annual ***gross*** income exceeds these guidelines ***you do not qualify*** and are ***not eligible to apply***.

Persons in Household	Maximum Income	Persons in Household	Maximum Income
1	$12,490	5	$30,170
2	$16,910	6	$34,590
3	$21,330	7	$39,010
4	$25,750	8	$43,430

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 requested:

_____

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

_____

_____

_____

_____

_____

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 secure funds for the above request through other sources?

_____

Was the request denied? ☐ Yes ☐ No

What was the reason for denial?: _____

*** Before submitting your application please make sure all three pages of the application are complete and signed and all required documentation requested on Page 1 is included. Only complete applications with all required documentation will be considered.**

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 certify by signing below that I have assisted the applicant to complete the application, that the information provided is current, accurate and has been verified by me or other agency staff.

_____ _____ _____ _____

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