



## Charitable Grant Program Application

Midwest Special Needs Trust

PO Box 7629 | Columbia, MO 65205

573.256.5055 Phone 573.303.5866 Fax

[grants@midwestspecialneedstrust.org](mailto:grants@midwestspecialneedstrust.org) Email

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### ELIGIBILITY – APPLICANTS MUST:

- Live in Missouri
- Be deemed disabled by the Social Security Administration (copy of Benefit Verification Letter required)
- Receive \$15,960 or less per year in Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

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### GRANT DETAILS

- Maximum grant: **\$2,000**
- Treatment plan or cost estimate required
- Grants are not guaranteed
- Decisions mailed within **4–6 weeks** (no phone notifications)

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### PAYMENT INFORMATION

- Payment made by check directly to the service provider
- Issued after services are completed
- Applicants must confirm provider accepts these terms before applying

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### NOT COVERED

- Services or items already received
- Vehicle purchases, repairs or fuel
- Home repairs
- Housing, food, utilities, or cash assistance
- Immediate or temporary dentures (complete dentures only)

### APPLICATION PROCESS

1. Complete the Application.
2. Submit Income Verification - Provide a copy of the applicant's Social Security Benefit Verification Letter. Include documentation for any additional income received.
3. Provide an Estimate or Treatment Plan
  - Estimates must be submitted as a formal letter from the business, including:
    - Contact information
    - Itemized list of required items
    - Exact cost of each item
  - Home Modifications
    - Estimates must be provided by a licensed contractor.
    - Proof of homeownership or a letter of approval from the landlord is required.
  - Medical Needs
    - A treatment plan from a licensed provider is required.
    - For hearing aids and eyeglasses, include a copy of the evaluation.
  - Medical Equipment, Exercise Equipment, Communication Devices, Lift Chairs, and Monitoring Systems - **A letter of recommendation from a licensed provider is required, explaining why the item(s) are needed.**

Type of Grant Requested (Select One):      \_\_\_\_\_ Urgent Grant                      \_\_\_\_\_ General Grant

- Urgent Grants are reviewed and awarded twice a month for urgent medical and dental needs not covered by public benefits or insurance.
- General Grants are reviewed and awarded once a month to help with needs not covered by public benefits.

**CONTACT INFORMATION**

Applicant Contact Information		
Applicant Name:	Date of Birth:	
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		
Guardian/Conservator Name:	Phone:	

Agency Representative Contact Information (if applicable)		
Agency Representative Name:		
Address:		
Agency/Company Name:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

**APPLICANT INFORMATION**

**1. Type of Disability (Mark all that apply):**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="radio"/> Mental Illness</li> <li><input type="radio"/> Physical Disability</li> <li><input type="radio"/> Developmental Disability</li> <li><input type="radio"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Brain Injury</li> <li><input type="radio"/> Spinal Cord Injury</li> </ul> |
|--|--|

**2. Living Situation (Mark all that apply):**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="radio"/> Lives Alone</li> <li><input type="radio"/> Lives with Spouse</li> <li><input type="radio"/> Lives with Children</li> <li><input type="radio"/> Lives with Parents</li> <li><input type="radio"/> Lives with Foster Parents</li> <li><input type="radio"/> Assisted Living</li> <li><input type="radio"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Group Home</li> <li><input type="radio"/> Independent Supported Living</li> <li><input type="radio"/> Residential Care Facility</li> <li><input type="radio"/> Habilitation Center</li> <li><input type="radio"/> Hospital</li> <li><input type="radio"/> Nursing Home</li> </ul> |
|--|--|

**3. Applicant receives the following monthly income(s). Mark all that apply:**

Income Source	Monthly Amount
Supplemental Security Income (SSI)	
Social Security Disability Insurance (SSDI)	
Social Security Retirement Income	
Employment (Include 2 recent paystubs)	
<b>Total Monthly Income</b>	

<b>Type of Public Benefit or Other Resources</b>		
<input type="radio"/> Medicaid	<input type="radio"/> Medicare	<input type="radio"/> Other

**4. Type of assistance requested:**

- |   |   |
|---|---|
| <input type="radio"/> Medical or Dental         | <input type="radio"/> Appliances            |
| <input type="radio"/> Hearing Aids or Glasses   | <input type="radio"/> Electronics           |
| <input type="radio"/> Durable Medical Equipment | <input type="radio"/> Home Modifications    |
| <input type="radio"/> Camp Fee                  | <input type="radio"/> Vehicle Modifications |
| <input type="radio"/> Conference and Event Fee  |   |
| <input type="radio"/> Other _____               |   |

**5. List the specific item or service that is needed:**

**6. Describe the applicant’s situation. Include why the item or service requested is needed and how it will benefit the applicant. Please provide as much information as possible.**

**How did you hear about the Charitable Grant Program?** \_\_\_\_\_

## ESTIMATE OR TREATMENT PLAN INFORMATION

7. Estimate or treatment plan total amount: \$ \_\_\_\_\_ (Include delivery/set-up fees)

### 8. Business Information:

Name of Business:		
Contact Person:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

9. If the estimate is greater than \$2,000, how will the remainder of the bill be paid?

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

Was the request Denied?       No       Yes       Unknown  
Reason for Denial \_\_\_\_\_

## APPLICATION CHECKLIST

### Include all the following documents:

- Application
- Social Security Benefit Verification Letter
- Treatment Plan or Estimate

### For hearing aids, glasses, or home modifications:

- Hearing Aids – Copy of Evaluation
- Glasses – Copy of Evaluation
- Home Modification – Proof of Home Ownership

## SIGNATURES: PLEASE SIGN BELOW

**Applicant:** 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 a denial of the request.

Furthermore, I understand and acknowledge that I am not guaranteed a grant.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Agency Representative (if applicable):** By signing below, I certify I have assisted the applicant to complete the application and that the information is accurate. I understand failure to provide accurate and complete information will result in a denial of the grant request. Furthermore, I also understand and acknowledge that the applicant is not guaranteed a grant.

Agency Representative: \_\_\_\_\_ Date: \_\_\_\_\_