Charitable Grant Program Application

Midwest Special Needs Trust
PO Box 7629 I Columbia, MO 65205
573.256.5055 Phone 573.303.5866 Fax
grants@midwestspecialneedstrust.org Email

ELIGIBILITY: APPLICANTS MUST

- Live in Missouri.
- Be deemed disabled by the Social Security Administration. Provide a copy of your Social Security Benefit Verification letter.
- Receive **$15,650** or less a year in Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

GRANT AMOUNT

The maximum grant amount is $2,000. A treatment plan or estimate detailing the cost is required.

GRANT INFORMATION

Charitable Grants are not guaranteed. Applicants are encouraged to continue to seek other funding opportunities. Applicants and Agency Representatives will receive a letter in the mail within 4-6 weeks. Grant award decisions will not be shared by phone.

GRANT PAYMENTS

All payments are made by check to the provider listed on the application ***after*** the service is provided. Applicants must contact the service provider prior to submitting the application to ensure the above payment terms are acceptable.

TYPES OF ASSISTANCE NOT PROVIDED

Grants will not be provided for (including, but not limited to):

- Services already completed or items already received,
- Vehicle expenses or purchases,
- Home repairs,
- Housing (rent, mortgage, room and board), food, utilities or cash,
- Immediate or Temporary Denture(s) [Complete Denture(s) only].

APPLICATION PROCESS

1. Complete the application.
2. Submit a copy of the applicant's Social Security Benefit Verification Letter. Include any other forms of income received.
3. Include the estimate or treatment plan.
    - Estimates must be a letter from the business including their contact information, list of item(s) needed and exact cost.
    - For home modifications, the estimate must be from a licensed contractor. Proof of home ownership or letter of approval from the landlord is required.
    - For medical needs, a treatment plan from a licensed provider is required. For hearing aids and eyeglasses, a copy of the evaluation is required.
    - For medical equipment, exercise equipment, communication devices, lift chairs and monitoring systems, a letter of recommendation from a licensed provider stating why the item(s) are needed is required.

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:		
Agency/Company Name:		
City:	State:	Zip:
Phone:		Fax:
Email:		

APPLICANT INFORMATION

1. **Type of Disability (Mark all that apply):**
   - ☐ Mental Illness
   - ☐ Physical Disability
   - ☐ Developmental Disability
   - ☐ Brain Injury
   - ☐ Spinal Cord Injury
   - ☐ Other _____

2. **Living Situation (Mark all that apply):**
   - ☐ Lives Alone
   - ☐ Lives with Spouse
   - ☐ Lives with Children
   - ☐ Lives with Parents
   - ☐ Lives with Foster Parents
   - ☐ Assisted Living
   - ☐ Group Home
   - ☐ Independent Supported Living
   - ☐ Residential Care Facility
   - ☐ Habilitation Center
   - ☐ Hospital
   - ☐ Nursing Home
   - ☐ Other _____

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)	
Total Monthly Income	$0.00

Type of Public Benefit or Other Resources		
☐ Medicaid	☐ Medicare	☐ Other

4. **Type of assistance requested:**

- ☐ Medical or Dental
- ☐ Hearing Aids or Glasses
- ☐ Durable Medical Equipment
- ☐ Camp Fee
- ☐ Conference and Event Fee
- ☐ Other _____
- ☐ Appliances
- ☐ Electronics
- ☐ Home Modifications
- ☐ Vehicle Modifications

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 of 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: _____