Incomplete applications will not be reviewed or returned. Please indicate that the following are enclosed:

Completed application form

2014 signed Federal Tax Form 1040

Documented Disability of Equipment Beneficiary

Equipment Documentation and Insurance Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Applicant Information  (Beneficiary of Equipment) | | | | | |
| First Name: | | Last Name: | | | |
| Date of Birth: | | Age: | | US Citizen: Y N | Sex: *M F* |
| Requestor: | | | | Relationship: | |
| Address: | | | | City: | |
| State: | Zip: | Email: | | | |
| Phone: | | Preferred Method of Contact: *Email Phone* | | | |
| Please List Other Household Members:  Name: Age:\_ Relationship: Name: Age:\_ Relationship: Name: Age:\_ Relationship: Name: Age:\_ Relationship: Name: Age:\_ Relationship: Name: Age:\_ Relationship: Name: Age:\_ Relationship: | | | | | |
| Please list and briefly explain all sources of financial support the beneficiary is currently receiving for disability related medical equipment: | | | | | |
| DDA: | | | MA Waivers: | | |
| Social Services: | | | Insurance: | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Local Education Agency (School): | | Others Grants or Financial Assistance: | |
| Please provide the medical diagnosis and equipment need:  *\*Documented support of diagnosis and medical need must be included in the application packet (e.g. medical report, insurance request/denial, medical prescription).* | | | |
| Grant Monies Request | | | |
| Equipment: | Provider Name: | | Provider Address: |
| Total Cost of Equipment – out of pocket*:*  *\*Documentation of cost must be included in the application packet* | | | Estimated Delivery Time: |
| Financial Income | | | |
| Household Member: | | Gross Monthly Income: | |
| Household Member: | | Gross Monthly Income: | |
| Household Member: | | Gross Monthly Income: | |
| Other Source: | | Gross Monthly Income: | |
| *Total Monthly Income:* | | |  |
| Liquid Assets | | | |
| Savings Account | | Recent Balance: | |
| Checking Account | | Recent Balance: | |
| Investments | | Recent Balance: | |
| *Total Liquid Assets:* | | | |
| *Additional Assets* | | | |
| Automobile(s) | | Value: | |
| Home | | Value: | |
| Other Property: | | Value: | |
| *Total Additional Assets:* | | | |

|  |  |
| --- | --- |
| Household Expenses | |
| Food | Monthly Expense: |
| Utilities | Monthly Expense: |
| Auto | Monthly Expense: |
| Child Care | Monthly Expense: |
| Housing (Mortgage/Rent) | Monthly Expense: |
| Insurance | Monthly Expense: |
| Other: | Monthly Expense: |
| Other: | Monthly Expense: |
| *Total Monthly Expenses:* | |
| Additional Expenses: | |
| Credit Cards | Balance: |
| Medical | Total Out-of-Pocket/Month: |
| Other: | Debt: |
| *Total Additional Expenses:* | |
| **Total Monthly Income (from above):** | |
| **Total Monthly Expenses (from above):** | |
| **NET disposable income:** | |

Please tell us about your situation and how the equipment will assist you and your family member in becoming a more confident, competent individual (500 words or less). You may use this space, the back of the form, or attach a typed document.

Please indicate you have reviewed and accepted the Terms and Conditions by signing below:

Signature of Applicant or Guardian Date