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

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| --- |
| 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