# COMMUNITY HEALTH OUTREACH PROJECT
# 2023 INDIVIDUAL APPLICATION FORM FOR FUNDING ASSISTANCE

## BEFORE YOU COMPLETE THIS APPLICATION FORM, PLEASE NOTE THE FOLLOWING:

1) Individuals with intellectual and developmental disabilities (I/DD) are eligible to receive critically or medically necessary equipment or services paid for by grant funds from the Community Health Outreach Project (CHOP). During 2023, only one application per household may be submitted, which is subject to a maximum allowance of $1,000.

2) You must provide the following documentation to accompany this application form:

   - ✓ A written notice from the Recipient's physician indicating why the item/service requested in the application is critically or medically necessary for the Recipient.
   - ✓ Since payment will be made directly to its source, you must provide documentation validating your request. Examples include, but are not limited to:

     - An invoice from a physician office/clinic that requires payment for services rendered.
     - A complete description, including manufacturer, model number, and cost of the item/equipment to be purchased, along with where the item/equipment will be purchased (i.e., a printout from Amazon). CP State will order and pay for the item/equipment from the supplier and have it shipped directly to the Recipient's residence.

## GENERAL INFORMATION ABOUT RECIPIENT

*CP State shall not disclose or otherwise make available any personally-identifiable information or protected health information (PHI) in connection with this Application.*

Recipient's Name: _____

Date of Birth: _____ County of Residence: _____

Address: _____

City: _____, NY Zip Code: _____

Phone: _____ Email: _____

Gender: [ ] Male [ ] Female

Ethnicity: [ ] White/Caucasian [ ] Hispanic
[ ] Black/African American [ ] Mixed Ethnicity
[ ] Asian/Pacific Islander [ ] Other: _____

Recipient has one or more of the following diagnoses: *(check all that apply)*

| | | |
|---|---|---|
| [ ] Autism Spectrum Disorder | [ ] Cerebral Palsy | [ ] Down Syndrome |
| [ ] Muscular Dystrophy | [ ] Neurological Impairment | [ ] Epilepsy |
| [ ] Intellectual Disability | [ ] Tourette Syndrome | [ ] Multiple Sclerosis |

[ ] Other(s): _____

## INSURANCE INFORMATION

Recipient is covered by the following insurance: *(check all that apply)*

[ ] Medicaid [ ] Medicare [ ] Private Insurance [ ] No Insurance

If the Recipient has Medicaid, Medicare, or Private Insurance, you must indicate WHY funding was denied or unavailable from the insurance program for the requested item or service:

_____

_____

_____

## GENERAL INFORMATION ABOUT CAREGIVER ***(Complete only if Recipient is not submitting this form on his or her own)***

Caregiver's Name: _____

Caregiver's relationship to the Recipient is: _____

Phone Number: _____ Email: _____

## TOTAL HOUSEHOLD INFORMATION

How many adults (18+) live in the home? _____ How many children (under 18) live in the home? _____

Please check the box that represents the Total Household Income, including work salary, SSI, SSD, child support, and all other income sources for all individuals living in the household. Household Income is defined as the combined gross income of all members of a household who are 15 years or older. Individuals do not have to be related in any way to be considered members of the same household.

| | | |
|---|---|---|
| [ ] $0 - $29,160 | [ ] $60,001 - $70,280 | [ ] $101,121 - $111,400 |
| [ ] $29,161 - $39,440 | [ ] $70,281 - $80,560 | [ ] $111,401 - $121,680 |
| [ ] $39,441 - $49,720 | [ ] $80,561 - $90,840 | [ ] $121,681 - $131,960 |
| [ ] $49,721 - $60,000 | [ ] $90,841 - $101,120 | [ ] $131,961 or more |

## FUNDING REQUEST

This request is for the following *(be specific)*: _____

_____

_____

_____

_____

*Examples*:
(a) *Shower Chair. The manufacturer is Medline, and the model number is MDS89745RA.*
(b) *Mental health evaluation as recommended by primary physician. Paperwork attached.*
(c) *Hearing Aid. The manufacturer is AudioUS and the model is the Wave.*

Please indicate the cost for the requested item or service that you would need funded by the Community Health Outreach Project: *(Reminder: The maximum amount of funding per household for 2023 is $1,000.)*

$_____

ATTACHMENT REQUIRED: Since payment will be made directly to the source, you must attach an invoice or cost sheet (i.e., Amazon printout) detailing the item/service and the vendor to be paid.

Please describe how this request will improve the Recipient's quality of life/health status and include justification as to why the item/service is needed. _____

_____

_____

_____

_____

_____

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_____

*Examples*:
(a) *Joe has trouble with his balance, and a shower chair will help in maintaining his independence while bathing. As a single mother, I prefer to allow him to shower alone.*
(b) *Joe has had a change in his interest levels in his daily routine and is acting out in ways that current treatment options cannot address. The clinic where he is a patient would like a mental health specialist to evaluate him. I am concerned that his aggression will result in damage to the home.*
(c) *Joe lost his left hearing aid and Medicaid will not pay for a new one for 3 years. He requires the hearing aid to maintain his ability to communicate properly with others.*

ATTACHMENT REQUIRED: The CHOP Awards Committee will consider funding requests that are critically or medically necessary for the Recipient. You must attach a written letter of recommendation from the Recipient's physician indicating why the requested item or service is absolutely necessary for the individual. Applications that do not include a physician's recommendation are ineligible for funding.

## REQUIRED – CONSENT TO RELEASE INFORMATION AND AFFIRMATION

I do hereby authorize all agencies, government programs, and insurance groups to release to the CP State, or its duly authorized representatives, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize CP State, or its duly authorized representatives, to provide such information to those institutions as may be reasonably required to assist the Recipient noted in this application.

I have read the "2023 Guidelines for Funding Assistance" and I affirm that the information furnished in this application form, including all supporting documentation, is true and accurate to the best of my knowledge. I further acknowledge that CP State may pursue restitution for funding if it is determined that the information submitted in this application is false. I agree to be bound by the decision of CP State and indemnify and hold them harmless from any and all claims, actions, and/or causes of action arising directly or indirectly as a result of such decision.

Recipient's or Caregiver's Signature: _____

Date of Application Submission: _____

## OPTIONAL – MEDIA RELEASE CONSENT

*If funding is awarded, we may wish to use Recipient's first name, photo, and story for marketing purposes to inform our Board of Directors and our funder, The Mother Cabrini Health Foundation, about the generous support provided by the Community Health Outreach Project and CP State.*

I do hereby give my permission to CP State, or its duly authorized representatives, to use the Recipient's first name, photo, and story in publications, presentations, social media, or on their website. I understand that these items will be used to inform interested parties about the Community Health Outreach Project and CP State's programs, services, or events. I also understand that this consent is not a requirement in order to receive funding assistance through CHOP. I gladly give this authorization to support CP State's efforts. I understand that this authorization shall continue until terminated in writing.

[ ] Yes [ ] No

Recipient's or Caregiver's Signature: _____

Date: _____

If you answered "Yes" to the Media Release Consent, please attached a photo of the Recipient. Thank you.

*If application is sent via mail*:
Cerebral Palsy Associations of NYS, Inc.
3 Cedar Street Extension, Suite 2
Cohoes, NY 12047
Attn: Cindy J. Morris, Project Director

*If a scanned application form is sent electronically*:
Send email with attachments to cmorris@cpstate.org.

*If application is sent via fax*:
Fax to (518) 436-8619, Attn: Cindy Morris

QUESTIONS? Email cmorris@cpstate.org or call Cindy Morris at 518-612-4510.

*Last Form Revision 2/4/2023*