Community Health Outreach Project
2024 Guidelines for Funding Assistance

The Community Health Outreach Project (CHOP) is a grant program funded by the Mother Cabrini Health Foundation and administered by the Cerebral Palsy Associations of New York State (CP State) to provide financial assistance for the purchase of equipment, services, supplies, and other supports needed by individuals with intellectual, developmental, and other significant disabilities when all other funding opportunities have been exhausted.

CHOP seeks to assist people with disabilities of all ages living within New York State by addressing the shortcomings in current funding systems. Funds through CHOP will provide access to supports for individuals in an effort to increase their health status and promote community participation. By removing barriers and offering assistance unavailable to them through other sources, CP State can do its part to improve social and environmental living conditions while promoting quality of life. CP State will focus on health measures and outcomes as well as the social determinants of health to identify priorities for funding and enable people to remain independent and active within their homes and communities.

Definitions

For purposes of clarification, please note the following definitions for this application form:

- Recipient – defined as the person with a disability who will receive the benefit of funding through this process
- Caregiver – defined as the person who tends to the needs of the Recipient

Eligibility Requirements

To be eligible for consideration of funding:

1) The Recipient must reside within New York State.
2) The item/service to be purchased must fall within the Project time period, which is January 1, 2024 through December 31, 2024.
3) The total Household Income must be at or below 200% of the 2024 federal poverty level to qualify, which is:

a. $30,120 or less for a household of 1
b. $40,880 or less for a household of 2
c. $51,640 or less for a household of 3
d. $62,400 or less for a household of 4
e. $73,160 or less for a household of 5
f. $83,920 or less for a household of 6
g. $94,680 or less for a household of 7
h. $105,440 or less for a household of 8
i. $116,200 or less for a household of 9
j. $126,960 or less for a household of 10

Funding Opportunities

CHOP provides funding for the purchase of equipment, services, supplies, and other supports needed by persons with disabilities when other funding options, such as Medicaid, Medicare, other government programs, private insurance, and other foundations/grants, have been explored and deemed unavailable. CHOP is not a reimbursement program, so you cannot apply for funding for purchases already made. Direct cash assistance is not provided under any circumstances.

Examples of funding opportunities include, but are not limited to:

mobility chairs
iPads (for communication needs)
hearing aids
shower chairs
hoyer lifts
wheelchairs
wearable GPS devices
activity chairs
bathroom safety bars
orthotics
portable wheelchair ramps
eyeglasses
bath lifts

Items that are excluded from the CHOP grant, but are not limited to:

beds
mattresses
furniture
environmental modifications
vehicle modifications
extended warranties
equipment assembly services
subscription fees

Please be sure that the item you request in the application form is the exact product/service needed by the Recipient. Once an item is ordered from a vendor, no returns or substitutions will be allowed.

All funding awards are determined by the CHOP Awards Committee based on the information submitted in your application.

Funding Limitations

This Project has a limited amount of funding to award during the year. Therefore, applications will be handled on a first-come, first-serve basis. Only fully-completed applications will be considered by the Awards Committee provided funding is still available at the time of receipt. There is no guarantee of funding or approval of your request.

During 2024, only one application per household may be submitted. The application is limited to one item or service and is subject to a maximum funding allowance of $1,000. If the amount of the item/service exceeds $1,000, the Recipient/Family will be responsible for paying the balance owed to the vendor for any amount over $1,000.

> ***NOTE**: If you are requesting funding for a Medicaid-approved service or device, the Awards Committee may deny your application. CHOP funds are available to assist when Medicaid rules prevent an individual from receiving a service or device in a timely manner (i.e., waiting three years for a new hearing aid).*
>
> *For example, if you are requesting funds for a particular speech therapist who does not accept Medicaid, your application may be denied since speech therapy is an approved Medicaid service and there are therapists available who do accept Medicaid.*

Payments

Payments from CHOP will be made directly to their sources such as suppliers, physician offices/clinics, or online vendors, as noted in your application and supporting documentation. CHOP will fund services to be rendered or equipment/supplies to be purchased during the Project period, which is January 1, 2024 through December 31, 2024. Direct cash assistance to applicants is not provided under any circumstances. Therefore, you cannot be reimbursed for payments already made to suppliers, contractors, agencies, physician offices, etc.

Supporting Documentation

In order to be considered for funding, appropriate documentation must be submitted with your application form, as noted below:

1) 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.
2) Since payment will be made directly to its source, you must provide documentation validating your request. Examples include:
   a. An invoice from a physician office/clinic that requires payment for services rendered.
   b. 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.

In all instances, you must indicate the reason why Medicaid/Medicare/Insurance Plan would not cover the cost for the requested service or item for the Recipient (see Page 2 of application form under "Insurance Information").

Consent to Release Information and Affirmation

All applicants must consent to release information to CP State for verification purposes and affirm that all information furnished in the application form and supporting documentation is true and accurate. A signature is required on Page 4 of the application form. Unsigned forms will be ineligible for funding.

Testimonial and Photo

If funding is awarded, we may wish to use Recipient's first name, photo, and story to inform our grant funder, The Mother Cabrini Health Foundation, about the generous support provided by the Community Health Outreach Project and CP State to the Recipient. Additionally, these testimonials assist CP State in securing new funding for 2025 so we can continue to offer CHOP to individuals in need. Your written testimonial would be greatly appreciated.

Submission Process

Applications must be completed in their entirety including the submission of supporting documentation. Incomplete or unsigned forms will be returned to the Recipient or Caregiver before any review by the Awards Committee.

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 Cindy Morris at cmorris@cpstate.org.

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

Award Process

Applications will be reviewed on a monthly basis by the Awards Committee. Fully-completed applications must be received by the deadlines noted below for review by the Awards Committee on the dates shown for each month.

Fully-Completed Applications Must Be Received By	*Applications Will Be Reviewed By Awards Committee On	Award Notifications Will Be Sent To Applicants By
January 22, 2024	January 29, 2024	February 5, 2024
February 19, 2024	February 26, 2024	March 4, 2024
March 18, 2024	March 25, 2024	April 1, 2024
April 22, 2024	April 29, 2024	May 6, 2024
May 20, 2024	May 28, 2024	June 4, 2024
June 17, 2024	June 24, 2024	July 1, 2024
July 22, 2024	July 29, 2024	August 5, 2024
~~ No Awards Committee Meeting will be held in August 2024 ~~~		
September 16, 2024	September 23, 2024	September 30, 2024
October 21, 2024	October 28, 2024	November 4, 2024
November 18, 2024	November 25, 2024	December 2, 2024
December 13, 2024	December 19, 2024	December 27, 2024

**The Awards Committee meeting dates may change slightly if unforeseen circumstances create scheduling conflicts.*

Questions

For further information or if you have any questions regarding the Community Health Outreach Project, please contact:

Cindy J. Morris
Project Director
Cerebral Palsy Associations of NYS, Inc.
Direct Phone: (518) 612-4510
Email: cmorris@cpstate.org

COMMUNITY HEALTH OUTREACH PROJECT
2024 INDIVIDUAL APPLICATION FORM FOR FUNDING ASSISTANCE

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

1) You are strongly encouraged to read the "2024 Guidelines for Funding Assistance" as it provides detailed information on the requirements of the Community Health Outreach Project (CHOP).

2) During 2024, only one application per household may be submitted, which is subject to a maximum funding allowance of $1,000. The application should only contain one (1) item/service. You cannot request multiple items on the application form.

3) 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 the vendor, 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.

Applications that are incomplete will not be accepted. You must complete all questions on this application form and submit it along with the appropriate supporting documentation.

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: _____ NYS County of Residence: _____

Address: _____ Apt # _____

City: _____, NY Zip Code: _____

Phone: _____ Email: _____

Gender: ◯ Male ◯ Female

Ethnicity:
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Prefer Not To Answer
- ☐ Other: _____

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

- ☐ Autism Spectrum Disorder
- ☐ Muscular Dystrophy
- ☐ Intellectual Disability
- ☐ Cerebral Palsy
- ☐ Neurological Impairment
- ☐ Tourette Syndrome
- ☐ Down Syndrome
- ☐ Epilepsy
- ☐ 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:

CAREGIVER INFORMATION

Caregiver's Name: _____

Caregiver's relationship to the Recipient is: _____

Phone Number: _____ Email: _____

If Recipient is receiving care management services, please provide:

Care Manager's Name: _____

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. THIS IS NOT THE INCOME OF JUST THE RECIPIENT. You must include all individuals living in the same household.

☐ $0 - $30,120	☐ $62,401 - $73,160	☐ $105,441 - $116,200
☐ $30,121 - $40,880	☐ $73,161 - $83,920	☐ $116,201 - $126,960
☐ $40,881 - $51,640	☐ $83,921 - $94,680	☐ $126,961 - $137,720
☐ $51,641 - $62,400	☐ $94,681 - $105,440	☐ $137,721 or more

☐ Check here to confirm that the amount indicated above is the total income combined for all individuals living in the same household with the Recipient.

FUNDING REQUEST

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

☐ Check here to confirm that the item indicated above is exactly what is needed for the Recipient. Once an item is ordered from a vendor, NO RETURNS or SUBSTITUTIONS will be allowed.

Please indicate the cost for the requested item/service that you would need funded by the Community Health Outreach Project. If the amount of the item/service exceeds $1,000, the Recipient/Family will be responsible for paying the amount above and beyond the CHOP funding grant.

$_____

☐ Check here to confirm your understanding that the recipient/family will be responsible for paying the balance owed to the vendor for any amount over $1,000, if the application is approved by our Awards Committee.

VENDOR INFORMATION

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.

☐ Check here to confirm that you have attached the vendor cost sheet or invoice.

JUSTIFICATION FOR THE REQUESTED ITEM/SERVICE

Please indicate why the item/service is medically or critically necessary for the Recipient at this time:

Please indicate how this item/service will improve the Recipient's health/quality of life:

You must attach a written letter of necessity from the Recipient's physician supporting your request for the item/service. Applications that do not include a physician's recommendation are ineligible for funding.

☐ Check here to confirm that you have attached the letter from the Recipient's physician.

ATTESTATION 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 "2024 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.

☐ By checking this box you give your consent to the above.

Date of Application Submission:

TESTIMONIAL AND PHOTO

If funding is awarded, we may wish to use Recipient's first name, photo, and story to inform our grant funder, The Mother Cabrini Health Foundation, about the generous support provided by the Community Health Outreach Project and CP State to the Recipient. Additionally, these testimonials assist CP State in securing new funding for 2025 so we can continue to offer CHOP to individuals in need.

If you receive a CHOP award, would you be willing to submit a testimonial and/or photo of the Recipient to be shared with The Mother Cabrini Health Foundation?

◯ Yes ◯ No

☐ By checking this box you give your consent to the above.

Date: _____

APPLICATION SUBMISSION

A schedule of monthly application submission dates and Awards Committee meetings are listed "2024 Guidelines for Funding Assistance". Please note that grant funds may be depleted before the end of 2024, so applications will be handled on a first-come, first-serve basis.

If application is being 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 application is being submitted electronically via fillable form/PDF or scanned application form:

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 1/18/2024