COMMUNITY HEALTH OUTREACH PROJECT
2025 APPLICATION FORM FOR AGENCY USE ONLY

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

1) You are strongly encouraged to read the "2025 Guidelines for Funding for Agencies" as it provides detailed information on the requirements of the Community Health Outreach Project (CHOP).

2) Your agency is eligible to receive critically or medically necessary equipment and/or services paid for by grant funds from the Community Health Outreach Project (CHOP). During 2025, funding will be limited to $10,000 for your agency for the year. Your agency may submit multiple applications throughout the year as long as the combined total of all applications submitted during 2025 does not exceed $10,000.

3) Each application should have only one (1) item listed with the individuals who will benefit from that item. However, you can combine multiple pieces of equipment into the same application if those items will be used in the same area (i.e., sensory room equipment, physical therapy equipment, dental equipment). Individuals/beneficiaries can only be named one time during the calendar year, so plan your applications accordingly. You cannot list the same individual in more than one application.

AGENCY INFORMATION:

Date of Application Submission: _____

Person Completing Application: _____

Title: _____

Phone Number: _____ E-Mail: _____

Agency Name: _____

Address: _____

City: _____, NY Zip Code: _____

REQUEST FOR FUNDING:

Indicate the amount you are requesting from the Community Health Outreach Project: $_____

Reminder … the amount being requested from CHOP needs to meet a minimum of $850 per beneficiary named in this application (Refer to the CHOP 2025 Guidelines for Funding for Agencies for further details).

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

_____

_____

_____

_____

Examples: Arjo Maxi Move Lift #KMCLUN-D; 3M Bair-Hugger Warming Gowns #81003 30/case; Reimbursement for uninsured medical, dental, and eye care service expenses for the individuals noted in this request; Panacea Extra Wide Wheelchair #A1-1111

PAYMENT REQUEST:

If this application is awarded, our agency is requesting payment as follow: ***(please select one)***

☐ Funding to be paid directly to the vendor based on the attached quote so our agency can purchase this item/service. A final price has been negotiated by our agency, and the vendor's quote is attached as documentation. *NOTE: You cannot submit a printout of an internet price unless a formal quote was received from the vendor. Your agency must contact the vendor to obtain a quote that includes delivery fees, if any, to your location.*

Make check payable to: _____

Mail to this address: _____

To the attention of: _____

☐ Funding to be paid directly to our agency for this item/service as follows: ***(please select one)***

_____ We will use the CHOP funds to pay the vendor directly after we order the item/service.

_____ We will use the CHOP funds as reimbursement since the item/service that we requested in this application has already been purchased during 2025. A paid invoice and proof of payment are attached as documentation.

Make check payable to: _____

Mail to this address: _____

To the attention of: _____

INDIVIDUAL DEMOGRAPHIC INFORMATION

Agencies must include demographic information on the individuals who will benefit from the item requested in this application. The amount requested from CHOP needs to meet a minimum of $850 per beneficiary named in this application. **Please refer to the "CHOP 2025 Guidelines for Funding for Agencies" for further details and examples.**

Please attach an Excel spreadsheet or typed listing of ALL BENEFICIARIES for the requested item(s) for this application to include the following information for each individual:

First Name	Last Name	Date of Birth	Gender	Ethnicity*	County of Residence

*Ethnicity choices are as follows:

- ✓ American Indian/Alaska Native
- ✓ Asian
- ✓ Black/African American
- ✓ Hispanic/Latino
- ✓ Native Hawaiian/Pacific Islander
- ✓ White
- ✓ Other
- ✓ Prefer Not to Answer

SUPPORTING DOCUMENTATION REQUIRED

Before submitting this application to CP State, confirm that you have attached the following:

☐ A paid invoice and proof of payment (if you are seeking reimbursement for a purchase made during 2025)
-OR-
A formal quote showing the **final negotiated price** from the vendor (if you are seeking payment to be made directly to the vendor).

☐ A written statement indicating that your agency sought funding for this request from all other sources, such as self-pay, Medicaid, Medicare, Government Programs, other foundations, other grant programs, etc., before applying to the Community Health Outreach Project. Sample language can be found in the 2025 Guidelines for Funding for Agencies.

☐ A written statement stating the reason why Medicaid, Medicare, Government Programs, other foundations, other grant programs, etc. would not cover the expense. Sample language can be found in the 2025 Guidelines for Funding for Agencies.

☐ Justification as to why this request is critically needed by your organization and how the equipment or service will improve the health status of the individuals named as beneficiaries.

☐ Demographic information on each individual/beneficiary who will benefit from this request, as noted above.

AFFIRMATION

I have read the "Community Health Outreach Project 2025 Guidelines for Funding for Agencies" 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 the Cerebral Palsy Associations of New York State, Inc. may pursue restitution for funding if it is determined that the information submitted in this application is false. For all purposes, any electronic signature affixed to the application shall be considered legally equivalent to an original handwritten signature and shall have the same force and effect.

Authorized Signature: _____

Printed Name: _____

Date: _____

EXECUTIVE DIRECTOR SIGNATURE

I approve the submission of this application to the Community Health Outreach Project and understand that my agency is limited to a maximum of $10,000 in total application requests for 2025. For all purposes, any electronic signature affixed to the application shall be considered legally equivalent to an original handwritten signature and shall have the same force and effect.

Executive Director Printed Name: _____

Executive Director Signature: _____

Date: _____

Questions

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

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