COMMUNITY HEALTH OUTREACH PROJECT
2025 INDIVIDUAL APPLICATION FORM FOR FUNDING ASSISTANCE

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

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

2) During 2025, 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 recommendation letter from the Recipient's physician indicating why the item/service requested in the application is critically or medically necessary.
   - ✓ 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

☐ Initial 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)*:

☐ Initial 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.

$_____

☐ Initial 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.

☐ Initial 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 recommendation letter 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.

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

SIGNATURE 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 "2025 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.

An electronic signature on this document shall be considered as an original signature for all purposes and have the same legal force and effect as a handwritten signature.

Recipient's or Caregiver's Signature: _____

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 2026 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

Recipient's or Caregiver's Signature: _____

Date: _____

APPLICATION SUBMISSION

A schedule of monthly application submission dates and Awards Committee meetings are listed "2025 Guidelines for Funding Assistance". Please note that grant funds may be depleted before the end of 2025, 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 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 1/22/2025