Cerebral Palsy Associations of New York State
Real people. Realizing potential.

Mother Cabrini HEALTH FOUNDATION

COMMUNITY HEALTH OUTREACH PROJECT
INDIVIDUAL APPLICATION FORM FOR FUNDING ASSISTANCE

GENERAL INFORMATION ABOUT RECIPIENT

CP of NYS, Inc. 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:
[ ] African American/African/Black/Caribbean
[ ] Asian/Pacific Islander
[ ] Caucasian
[ ] Hispanic/Latino
[ ] Native American
[ ] Other: _____

Is Recipient covered by …

Medicaid?	[ ] Yes	[ ] No
Medicare?	[ ] Yes	[ ] No
Private Insurance?	[ ] Yes	[ ] No
Other? _____	[ ] Yes	[ ] No

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): _____

How did you hear about the Community Health Outreach Project?

[ ] Agency/Chapter
[ ] CP of NYS Website
[ ] Care Coordinator
[ ] Internet Search
[ ] Advertisement *(indicate which publication)*: _____
[ ] Other *(please specify)*: _____

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: _____

HOUSEHOLD INFORMATION

Please check the box that represents the Recipient's Household Income, including work salary, SSI, SSD, child support, and all other income sources. 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. Be as accurate as possible as income verification may be requested.

[ ]	$0 - $25,760	[ ]	$62,081 - $71,160	[ ]	$107,481 - $116,560
[ ]	$25,761 - $34,840	[ ]	$71,161 - $80,240	[ ]	$116,561 - $125,640
[ ]	$34,841 - $43,920	[ ]	$80,241 - $89,320	[ ]	$125,641 - $134,720
[ ]	$43,921 - $53,000	[ ]	$89,321 - $98,400	[ ]	$134,721 - $143,800
[ ]	$53,001 - $62,080	[ ]	$98,401 - $107,480	[ ]	$143,801 or more

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

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) Ramp built over the front steps of our home. Cost estimate attached.

If the Recipient has Medicaid, Medicare, or Private Insurance, please indicate WHY funding was denied through one or more of these programs?

_____

_____

_____

_____

_____

Please indicate the cost for the requested item or service that you would need funded by the Community Health Outreach Project:

$_____

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

_____

_____

_____

_____

_____

_____

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 can no longer walk up the front stairs to enter our home. He will maintain his mobility with his walker, and he has the strength to push the walker up a ramp.

If you are awarded funding through the Community Health Outreach Project, we will provide funds directly to the source. Therefore, you must supply documentation to identify the vendor, item, and cost, such as:

- Supplier – attach a copy of the cost estimate of the item/service to be purchased or invoice to be paid.
- Contractor – attach a copy of the estimate or invoice from the contractor for modifications or repairs.
- Clinic/Physician Office – attach a copy of the invoice to be paid for the services provided.

REQUIRED – CONSENT TO RELEASE INFORMATION AND AFFIRMATION

I do hereby authorize all agencies, government programs, and insurance groups to release to the CP of NYS, or its duly authorized representatives, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize CP of NYS, 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 "Community Health Outreach Project 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 of NYS 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 of NYS 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 name, county of residence, and photo for marketing purposes to inform our Board of Directors, families, media, and the general public about the generous support provided by the Community Health Outreach Project and CP of NYS.

I do hereby give my permission for CP of NYS, or its duly authorized representatives, to use the Recipient's name, county of residence, and photo in publications, presentations, videos, or on their website. I understand that these items will be used to inform interested parties about the Community Health Outreach Project and CP of NYS's programs, services, or events. I also understand that this consent is not a requirement in order to receive funding assistance through this Project. I gladly give this authorization to support CP of NYS'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.

Return completed application form to:

Cerebral Palsy Associations of NYS, Inc.
3 Cedar Street Extension, Suite 2
Cohoes, NY 12047
Attn: Cindy Morris

Or via fax to: *(518) 436-8619 to the attention of Cindy Morris*

Or electronically to: *cmorris@cpstate.org*

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