



Community Fund Management Foundation d/b/a Community Fund Ohio

Grant Application for Individual

STEP 1: PLEASE READ THE FOLLOWING INSTRUCTIONS

HOW TO SUBMIT AN APPLICATION

The enclosed application form must be filled out completely, typed or legibly written in black or blue ink, single-sided, and on 8.5x11" paper. No more than twenty (20) single-sided pages will be accepted. Completed applications should be sent to Community Fund Ohio's Administrative office via regular mail or fax (not email):

**Attn: Grants
Community Fund Ohio
17900 Jefferson Park, Suite 102
Middleburg Heights, OH 44130
Phone: (216) 736-4540
Fax: (216) 867-9783**

WHEN TO APPLY AND HOW APPLICATIONS WILL BE REVIEWED

Applications may be sent to Community Fund Ohio at any time but will be reviewed after the end of each quarter. Community Fund Ohio's deadline to receive completed applications is the last day of each quarter as follows:

March 31, June 30, September 30, and December 31.

Each applicant will receive a confirmation letter within 2-3 weeks after the application is received. If an application is incomplete or lacks required supporting documents, the sender will be notified if the sender's information can be identified. Applications that remain incomplete or are missing supporting documents at the quarterly deadline will be denied.

Community Fund Ohio's Planning Committee will review all complete, submitted applications on a quarterly basis after March 31, June 30, September 30, and December 31. Only those applications that are complete and that meet all eligibility criteria and requirements will be considered for approval. However, the Committee has complete discretion to approve or deny any application, even if it meets all requirements.

Each applicant shall be notified of the Committee's decision within forty-five (45) days after the end of the quarter. Applicants who receive a denial may submit a new application in a future quarter.

Due to the quarterly review and approval schedule, available funds could be exhausted before the end of the calendar year, so it may be in applicants' best interest to submit applications early in the calendar year.

Grant Application for Individual

STEP 2: COMPLETE THIS CHECKLIST TO DETERMINE ELIGIBILITY

1. Does the Grant Applicant live in Ohio?

NO – Stop. Grants are available only for Ohio residents.

YES – Continue.

2. Does the Grant Applicant have a disability?

NO – Stop. Grants are available only for people with disabilities.

YES – Continue.

3. Is a grant being requested to pay for a disability-related item or service?

NO – Stop. Grants are available only for disability-related items or services.

YES – Continue.

Please note that the following categories are excluded or limited:

- Grant requests to pay health insurance deductibles will not be considered.
- Grant requests to pay probate court or other court fees will not be considered.
- Grant requests to pay for ABA Therapy will not be considered.
- Grant requests to pay past due balances may be considered but other applications will be given priority.

Please note that the following categories require additional documentation:

- If applying for funding for therapy services, the Applicant must submit a copy of a medical prescription or written recommendation from a licensed physician who is treating the Applicant's disability and is independent from the therapy provider. Applications lacking this documentation will not be considered.

STEP 3: COMPLETE THIS CHECKLIST TO SELECT THE CORRECT GRANT TYPE

1. Does the Grant Applicant receive any of the following government benefits?
Please check "No" or "Yes" for each and every item.

- NO** **YES*** Supplemental Security Income (SSI)
- NO** **YES*** Aged, Blind, and Disabled (ABD) or Community Medicaid
- NO** **YES*** Modified Adjusted Gross Income (MAGI) Medicaid
- NO** **YES*** Healthy Start/Healthy Families Medicaid or CHIP
- NO** **YES*** Medicaid Buy-In for Workers with Disabilities (MBIWD)
- NO** **YES*** Waiver (if YES, list type: _____)

If you answered NO to ALL benefits listed above, this Application is for:

Special Needs Grant (\$1,500 lifetime maximum).

Skip to STEP 4 on page 4 of this packet.

*** If you answered YES to ANY benefits listed above, this application is for:**

Special Needs Grant with Financial Hardship (\$5,000 lifetime maximum).

The following documentation must be attached:

- Supplemental Security Income (SSI) Award Letter or SSI statement from the Social Security Administration dated within the past 12 months -OR-
- Proof of Medicaid or Waiver approval dated within the past 12 months.

List the SSI, Medicaid, or Waiver documents attached (required):

- a. _____
- b. _____
- c. _____

For both grant types, please complete the rest of this application and submit pages 2-7 of this packet to Community Fund Ohio. You may keep page 1 for your records.

STEP 4: COMPLETE ALL OF THE FOLLOWING INFORMATION

A. Grant Applicant

This application is for the following Ohio resident with a disability:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
SSN: _____ Date of Birth: _____

Has a Community Fund grant application been previously submitted for this Applicant?

NO YES → If YES, what was the outcome of the previous application?
_____ Denied _____ Approved \$ _____ Amount Awarded

Is the Grant Applicant a current or former Beneficiary of a Trust administered by Community Fund Management Foundation d/b/a Community Fund Ohio?

NO YES → If YES, please provide the Trust Agreement Number: _____

B. Submission Applicant

This application is being submitted by the following person: *(check one)*

- _____ Grant Applicant listed above *(Skip to section C on page 5 of this packet)*
- _____ Parent / Immediate Family Member of Grant Applicant
- _____ Legal Guardian of Grant Applicant *(Attach a copy of the Letters of Guardianship)*
- _____ Community Fund Designated Advocate for Grant Applicant *(applies only to an Applicant who is a current or former Beneficiary of a Community Fund Trust)*

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____
Relationship to Grant Applicant: _____

Please initial to indicate your compliance with the following statement:

Initials: _____ As the Submission Applicant, I certify that I have authority to apply for a grant on behalf of the Grant Applicant, and I am completing this application in good faith.

C. Information Regarding Grant Applicant

1. Please describe the Grant Applicant's disability: _____

2. **Documentation of disability.** Please attach the following documentation to show that the Grant Applicant is an individual with a disability:

- SSI or SSDI Award Letter or statement from the Social Security Administration dated within the past 12 months, showing the type of benefits received -OR-
- Proof of Medicaid or Waiver approval dated within the past 12 months -OR-
- The first page and signature page of an IEP, ISP, or IFSP dated within the past 12 months.
- If the Grant Applicant cannot provide the documentation listed above but is a person who meets the Social Security Administration's definition of disability, please call Community Fund to determine what types of documentation may be accepted.

List the documents attached that verify the Grant Applicant's disability (required):

- a. _____
- b. _____
- c. _____

D. Information Regarding Grant Request

1. **Amount Requested:** \$ _____

***Please Note:** A qualifying individual may submit multiple grant applications. However, the combined total of all grants cannot be more than the lifetime maximum for the grant type (either \$1,500 or \$5,000, depending on grant type). No individual shall be awarded more than \$5,000 over his/her lifetime.*

2. **Grant Check Information:** Grant checks will usually be issued directly to vendors and service providers, not to individual Grant Applicants. If this grant is awarded, the check should be made payable to the following vendor or service provider:

Vendor Name: _____

Contact Person (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Website: _____

Please note the following regarding issuance of grant checks:

- Checks will be issued to no more than two (2) vendors or service providers.
- Grant checks can be issued to online vendors only if the vendor accepts third-party checks. Some online vendors do not. Please confirm with the vendor before applying.
- If requesting a grant check payable to someone other than a vendor or service provider, please explain here. Community Fund may not be able to honor all requests. Community Fund will not make grant checks directly payable to SSI recipients or others whose public benefits eligibility could be affected. _____

3. **Documentation of vendor and cost.** Please attach the vendor’s quote, invoice, bill, or receipt to support the dollar amount requested. The documentation must show the vendor’s business name, address, and phone number; the itemized cost of the item or service to be funded; and if applicable, the dates that services will be provided.

List the documents attached from the vendor (required):

a. _____

b. _____

c. _____

4. **Reasons for Application.** Please answer each and every item below, “a” through “e.” Attach additional pages if necessary.

- a. Explain reasons for grant request (why grant is needed, how Applicant will benefit).

- b. Explain how the item or service is directly related to Applicant’s disability.

c. Describe any other financial resources available to pay for the item or service.

d. If grant will not fully cover the cost, explain how Applicant plans to pay the balance.

e. Provide any other information that will help the Committee understand the request.

5. **Grants to pay for therapies.** If applying for funding for therapy services, the Applicant must submit a copy of a medical prescription or written recommendation from a licensed physician who is treating the Applicant's disability and is independent from the therapy provider. Applications lacking documentation to support a grant for therapy services will not be considered.

List the documents attached for therapy funding requests (if applicable):

a.

b.

c.

By signing my name below, I understand and agree to the following:

- All information provided in this grant application is true and accurate.
- Community Fund Ohio Individual Grants are limited to a lifetime total of either \$1,500 or \$5,000 per Grant Applicant, depending on grant type.
- To evaluate this grant request, Community Fund Ohio will rely solely on this application and on any written supplement to this application that I submit, not to exceed twenty (20) single-sided pages in total.
- If this application remains incomplete or lacks required supporting documents on the last day of the quarter in which it was submitted, it will be denied, and I will be notified.
- Community Fund Ohio is not responsible if it approves this grant request and the receipt of grant funds causes the recipient or his/her family to lose eligibility for government benefits or otherwise be penalized or harmed by the grant approval. The Submission Applicant is responsible for understanding the ramifications of approval.
- The Grant Applicant and the Submission Applicant will cooperate with Community Fund Ohio and provide requested documentation to confirm that the funds are being used for the requested and intended purpose, should this application be approved.
- In the event that this application is approved, the Grant Applicant agrees that Community Fund Ohio may disclose the approval, amount, and reason for the grant, but not the Applicant's name, address, or personal identification information, on Community Fund Ohio's website, annual report, or through other written or electronic means at Community Fund Ohio's sole discretion.

Signature of Submission Applicant

Date

Printed Name of Submission Applicant

Note: *Inked signature is required. If you are completing this form electronically, please print the completed version, sign in blue or black ink, and fax or mail to Community Fund Ohio. Community Fund Ohio does not accept grant applications by email. Please see page 1 of this packet for detailed submission instructions.*