Community Fund Management Foundation

Application for Individual Grant Request for People with Disabilities

This Application is for: (*check one*)

____ Hardship/Emergent Needs Grant ____ Educational Assistance Grant for Individual / Family Member

Grant Applicant

This Grant is being applied for on behalf of the following person:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

SSN: _____ Date of Birth: _____

Has an Application for Individual Grant Request been previously submitted for this Grant Applicant? _____ No _____ Yes

Please describe the Grant Applicant's disability: _____

_____

Submission Applicant

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

_____ Same as Grant Applicant (*It is not necessary to complete the following section*)

_____ Parent / Immediate Family Member / Guardian for Grant Applicant (*Please complete the following section*)

_____ CFMF Designated Advocate for Grant Applicant (*Please complete the following section*)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____ _____

Relationship to Grant Applicant: _____

Information Regarding Grant Request

1. Amount Requested: $_____ (*Lifetime Maximum: $1,500.00)*
2. Check Made Payable To: ____ Grant Applicant ____ Other: _____
3. Detailed explanation of reason for Grant Request: (*Use additional pages if necessary.*)

_____

_____

_____

_____

4. Please attach detailed documentation to support the Grant Request, such as a quote, seminar curriculum, travel itinerary, invoice, proposal, etc.

Information Regarding Grant Applicant

1. Is the Grant Applicant a current or former beneficiary of a CFMF trust? If yes, please provide the Trust Agreement Number: _____

2. Does the Grant Applicant have any pending applications for government benefits?

☐ NO ☐ YES (explain below)

If YES, what applications are pending?_____

3. Grant Applicant Income Information (*include a copy of current Social Security benefit statement*)

Wages/Earnings ..... ☐ No ☐ Yes $_____Monthly

If Yes, Employer:_____ Address: _____ City: _____

Social Security Administration (SSA) Benefits (retirement)..... ☐ No ☐ Yes* $_____Monthly

Supplemental Security Income (SSI) Benefits..... ☐ No ☐ Yes* $_____Monthly

Social Security Disability (SSD) Benefits..... ☐ No ☐ Yes* $_____Monthly

Social Security Spouse's Benefits ..... ☐ No ☐ Yes* $_____Monthly

Social Security Children's Benefits..... ☐ No ☐ Yes* $_____Monthly

Ohio Works First (OWF, formerly ADC) ..... ☐ No ☐ Yes* $_____Monthly

Temporary Assistance for Needy Families (TANF) ..... ☐ No ☐ Yes* $_____Monthly

Prevention, Retention and Contingency Program (PRC) ..... ☐ No ☐ Yes* $_____Monthly

Disability Assistance (DA) ..... ☐ No ☐ Yes* $_____Monthly

Veterans Administration (VA) Benefits ..... ☐ No ☐ Yes* $_____Monthly

Railroad Retirement Benefits ..... ☐ No ☐ Yes* $_____Monthly

Black Lung Benefits..... ☐ No ☐ Yes* $_____Monthly

Child Support..... ☐ No ☐ Yes* $_____Monthly

Other Benefits: _____ ... ☐ No ☐ Yes* $_____Monthly

☐ **The Grant Applicant does not receive wages or government benefits.**

*****If YES for any of the above, except Wages/Earnings, who is the check payable to (payee)?

☐ Grant Applicant ☐ Other (Payee's Name)_____

4. Other Resources

Food Assistance ..... ☐ No ☐ Yes $_____Monthly

Other..... ☐ No ☐ Yes $_____Monthly

5. Medical Coverage

Medicaid ..... ☐ No ☐ Yes

Do you have a spend down?..... ☐ No ☐ Yes, If YES, amount $_____

Do you receive Waiver services? ..... ☐ No ☐ Yes

If you receive a Waiver, please provide type: _____

Medicare..... ☐ No ☐ Yes

Other (private, third-party insurance)..... ☐ No ☐ Yes

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

- The information provided on this form is accurate.
- Grants are limited to a lifetime total of $1,500 per Grant Applicant.
- CFMF will rely solely on the information provided by me in order to evaluate this grant submission.
- Incomplete requests will be returned to me and will not be considered for approval.
- CFMF will not approve grant requests that could jeopardize a person's eligibility for government benefits.
- CFMF is not responsible if it approves this grant request and the receipt of 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 person submitting this grant request is responsible for understanding the ramifications of its approval before it is submitted.
- The Grant Applicant and Submission Applicant will cooperate with CFMF and provide requested documentation to confirm the funds are used for the requested and intended purpose should this Application be approved.

- In the event this Application is approved, the Grant Applicant agrees that CFMF may disclose the approval, amount, and reason for the grant, but not the Grant Applicant's name or address, on CFMF's website, annual report, or through other written or electronic means in CFMF's sole discretion.

Signature of Submission Applicant

Date

Printed Name of Submission Applicant

Completed applications should be sent to CFMF's Administrative office via regular mail or fax:

Community Fund Management Foundation
Attn: Planning Committee
17900 Jefferson Park
Suite 102
Middleburg Heights, OH 44130
Phone: 216/ 736-4540
Fax: 216/ 867-9783

For internal purposes only:

		Date Received by CFMF Administrative Office
		Quarter Review Date
		Date Confirmation Letter Sent or Incomplete Submission Returned Due: _____
		Entered into Review Docket Due: _____
		Date Reviewed by Endowment Committee Due: _____
		Date Reviewed by Executive Director Due: _____
		Date Result Letter Sent Due: _____
		Date Funds Sent (If Approved) Due: _____