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 **Independence, Inc. Assistive Technology**

 **Grant Application**

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Disability or Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Date of onset of disability: \_\_\_\_\_\_\_\_\_\_

Equipment or home modification requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount requested from this grant fund: $\_\_\_\_\_\_\_\_\_\_\_\_ **(Please review the AT Grant Program Policy & Procedures for information about the possible grant amount and application process.)**

Total Cost: \_\_\_\_\_\_\_\_\_\_\_

List the source(s) and amount(s) of matching funds, which together with the requested AT Grant equals 100% of the total cost. Matching funds may include personal contributions.

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Gross annual family income: $\_\_\_\_\_\_\_\_\_\_\_\_ Number of persons living in the household: \_\_\_

**When returning the application, include documentation of income and bids from vendors.**

Will your insurance cover any the cost involved? Yes No

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is applicant eligible for and/or receiving assistance from: (Select all that apply.)

Health Wave Medicare

Kansas Special Health Services Social Security

Medicaid (KanCare) Supplemental Security Income (SSI or SSDI)

Do you have a prescription or professional recommendation for the item requested? Yes No

If yes, from whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ please enclose a copy.

**When returning application:** If applicant is 18 or over, enclose documentation of gross annual income such as pay stubs, two months of consecutive bank statements, social security benefit letter, etc. If the applicant is under 18, enclose documentation of parents’ gross annual income. Enclose one invoice/bid for assistive technology. Enclose two bids for a proposed accessible housing modification.

I certify that the information provided above is accurate and I agree to complete a follow-up questionnaire if provided with grant funding. By signing this application I am giving Independence, Inc. permission to communicate with the funding sources and vendors listed above that are contributing to this project.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return application to: Mary Ann Newton, AT Grant Coordinator

Independence, Inc.

 215 W. 6th, Suite 105A

Emporia, KS 66801

 Email: MNewton@independenceinc.org Phone: 620-341-9002; Fax: 620-208-9003