Midwest Special Needs Trust

Charitable Trust Grant Program
Application for Assistance

Revised 08-15

Return the application with required documentation to:
Midwest Special Needs Trust
P.O. Box 7629
Columbia MO 65205
Email: grants@midwestspecialneedstrust.org
Ph (573) 256-5055 Fax 1-(573) 303-5866

Eligibility:
Applicant must be a Missouri resident and have a mental, developmental or physical impairment that limits functioning in one or more major life activities and meet income eligibility guidelines (2015 Federal Poverty Income Guidelines) below:

Persons in Household	Maximum Income	Persons in Household	Maximum Income	Persons in Household	Maximum Income
1	$11,770	3	$20,090	5	$28,410
2	$15,930	4	$24,250	6	$32,570

Application Guidelines:
The maximum grant award is $1500. Grants may be requested for medical and dental care and equipment, rehabilitation training services or devices, personal goods and services, educational assistance and transportation. Rent, utilities and food cannot be funded. Grant funds will ***NOT*** be awarded for goods purchased or services performed prior to award. Applicants must provide proof of income and disability. Incomplete applications will not be accepted.

All applications ***must*** include an estimate or a current treatment plan from a vendor or other documentation of the cost of the service or item(s) requested. If the request is for dental care, a treatment plan from a dental service provider ***must*** be enclosed with the application, and ***must*** include contact information for the provider.

Types of Grants Available:
General Charitable Grant: This type of grant is available to *supplement basic needs* by providing disability related goods and services which are beyond the financial means of the individual. Grants are awarded by the Board of Trustees on a quarterly basis. The deadlines for these applications are: March 31, June 30, September 30 and December 31. Applications must be received by 4:30 pm on or before the deadline date.

Urgent Medical and Health Care Grant: This type of grant is available *only* for *urgent medical and health care needs* which require immediate intervention. Applications are accepted on an ongoing basis and grant awards are made twice each month.

All applicants and agency sponsors will receive written notice of approval or denial of the application.

This application is for (check one): **Date:** _____
☐ **General Charitable Grant** ☐ **Urgent Medical and Health Care Grant**

Contact Information

1. Applicant Information

_____
Name

_____
Street Address

_____
City **State** **Zip Code**

_____
Phone Number

_____
Email Address*
***Email address will be utilized for written communication from MSNT if provided**

2. Agency Representative (If applicable)

_____
Name

_____
Organization

_____
Street Address

_____
City **State** **Zip Code**

_____
Phone Number

_____
Email Address*
***Email address will be utilized for written communication from MSNT if provided**

Applicant Background Information

3. Date of Birth: _____-_____-_____

4. Type of Disability:

- ☐ Mental Illness
- ☐ Developmental Disability or Mental Retardation
- ☐ Brain Injury/Spinal Cord Injury (circle one)
- ☐ Physical Disability (Must specify)

_____

PROOF OF DISABILITY
Verification from Social Security of SSI or SSDI eligibility and benefit must accompany the application.

5. Living Situation:

Lives independently in own home or apartment

☐ Lives Alone ☐ Lives with Spouse/Children (circle one) ☐ Lives with Parents
☐ Lives with Foster Parents ☐ Live with Other; Describe _____

- ☐ Lives in a supported living setting (< 24 hour supported care)
- ☐ Lives in a supervised living setting (24 hour supervised care)

6. If living in 24 hour supervised care, please describe more specifically:

- ☐ Staffed apartment or assisted living facility
- ☐ Group home or residential treatment facility
- ☐ ISL (Individualized Supported Living)
- ☐ RCF (Residential Care Facility)
- ☐ Nursing home
- ☐ State-operated facility (specify) _____
- ☐ Other (specify) _____

7. Applicant receives the following monthly public benefits:

- ☐ Social Security Supplemental Income $_____
- ☐ Social Security Disability Income $_____
- ☐ Social Security Retirement Benefit $_____
- ☐ Food stamps
- ☐ Medicaid
- ☐ Medicare
- ☐ Other benefits (specify) _____
- ☐ Applicant receives no public benefits

PROOF OF INCOME FOR *ALL* HOUSEHOLD MEMBERS
The applicant must provide proof of gross income for all household members. Examples of acceptable documentation of income include, but are not limited to, a letter from the Social Security Administration listing benefits and amount, a copy of the applicant's social security check for the previous month or a copy of tax forms filed with the IRS for the previous year.

8. Household income:

Number of persons in household: _____
Gross annual income of all members of the household: $_____

9. Type of assistance requested:

- ☐ Medical and dental care and equipment
- ☐ Rehabilitation training, services or devices
- ☐ Supplemental education assistance
- ☐ Personal goods and services
- ☐ Transportation

Description of Request for Assistance

10. Briefly describe the specific item or service that is requested:

_____

11. Describe the applicant's situation. Include why the item or support requested in #10 above is needed and how it will benefit the recipient:

_____

_____

_____

_____

_____

12. Amount Requested*: $_____ (Maximum Grant is $1,500)

*An estimate or current treatment plan from the vendor or other documentation of the cost of the item(s) requested must be enclosed. If the request is for dental care, a treatment plan **must** be enclosed.

Outside Resources

13. Has an effort been made to secure funds for above request through other sources?

☐ Yes
☐ No

If yes, to whom (agency or resource) was the request made?

_____

Was the request denied?

☐ Yes What was the reason for denial?: _____
☐ No

Please Sign Below

By signing below, I attest to the truth and accuracy of all information provided in this application. I understand that failure to provide accurate and complete information will result in denial of the request.

I certify by signing below that I have assisted the applicant to complete the application, that the information provided is current, accurate and has been verified by me or other agency staff.

_____ _____
Applicant Signature **Date**

_____ _____
Agent/Advocate Signature (If applicable) **Date**