Charitable Fund Application

Please visit www.arcare.org for more information and/or to fill out your application online.

Part One: Personal Information

1. Application Information

Applicant Name _____ DOB _____

Street Address _____ City _____ State _____ ZIP _____

Phone _____ Email _____

2. Agency Representative (if applicable)

Representative's Name _____ Organization _____

Street Address _____ City _____ State _____ ZIP _____

Phone _____ Email _____

3. Type of Disability (check only 1)

☐ Mental Illness ☐ Brain Injury ☐ Intellectual Disability

☐ Physical Disability *(please specify)* _____

4. Living Situation (check only 1)

☐ Lives independently in own home or apartment

☐ Lives with family

☐ Lives with foster family

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

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

If in a supervised living setting, please describe more specifically:

☐ Staffed Apartment ☐ Group Home ☐ Nursing Home ☐ Other _____

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5. Applicant Benefits*

- ☐ Supplemental Security Income (SSI) $ _____ per month
- ☐ Social Security Disability Insurance (SSDI) $ _____ per month
- ☐ Food Stamps/Vision Card $ _____ per month
- ☐ Medicaid or Working Healthy $ _____ per month
- ☐ Other Benefits $ _____ per month
- ☐ Applicant receives no public benefits

***Applicant must provide proof of income via a letter from SSA listing the benefit amount, paycheck stub or income tax form from the previous year.**

6. Representative Payee

☐ Yes *(If Yes, please list the provider.)* ☐ Arcare ☐ Other _____

☐ No

Part Two: Application Specifics

7. Type of Assistance Requested

- ☐ Medical and dental care and equipment
- ☐ Rehabilitation training, services or devices
- ☐ Supplemental education assistance
- ☐ Home repairs and maintenance
- ☐ Transportation/auto repairs and maintenance
- ☐ Personal goods and services

8. Briefly describe the specific item or service requested.

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9. Describe the applicant's situation. Include why the item or support requested above is needed and how it will benefit the recipient.

10. Amount Requested* $ _____

***An estimate 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 attached.**

11. Outside Resources

Has the applicant applied for a grant through the Arcare Charitable Fund in the past? ☐ Yes ☐ No

Has an effort been made to secure funds for the above requested through other sources? ☐ Yes ☐ No

*If Yes, to whom (agency or resource) was the request made?*_____

Was the request denied? ☐ Yes ☐ No

If Yes, what was the reason for denial? _____

Signature

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.

_____ _____

Applicant Signature Date

I certify by signing below that the applicant has a disability and that the income amounts shown in this application are current and accurate, and have been verified by me or other agency staff.

_____ _____

Agent/Advocate Signature (if applicable) Date

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