**B. Thomas Golisano Life Enhancement Fund
Future Care Planning Community Pooled Trust Application**

**Application Date** Click or tap to enter a date.

**1. Beneficiary Information**

Name:Click here to enter text.

Address (Street, City, State, Zip): Click here to enter text.

County Click here to enter text.

Phone: Click here to enter text. Email: Click here to enter text.

Social Security # Click here to enter text.

Does applicant receive SSI? [ ] Yes [ ] No

Does applicant have approved: [ ] Medicaid [ ] Medicare

 [ ] Other health insurance

Does applicant have a supplemental needs trust: [ ] Yes [ ] No

Description of disability:

[ ] Intellectual/developmental

[ ] Epilepsy

[ ] Cerebral palsy

[ ] Neurological impairment

[ ] Autism

[ ] Traumatic brain injury

[ ] Physical

[ ] Mental health

[ ] Other: Click here to enter text.

Proof of Disability (check which document is attached):

[ ]  Social Security Disability Determination

[ ]  NYS Department of Human Services (DHS) Notice of Medicaid Disability Determination

**2. Additional Applicant Information (Optional)**

Date of birth: Click here to enter a date. Gender: [ ] Male [ ] Female [ ]  Transgender

Ethnicity: Click here to enter text.

Name of caregiver: Click here to enter text. Relationship: Click here to enter text.

**3. Please List Goods or Services Requested:** Click here to enter text.

Total Cost of Requested Goods or Services: Click here to enter text.

Total Amount Requested from the Fund: Click here to enter text.

**4. Please Describe How This Item/Service Will Enhance the Beneficiary’s Life:**

Click here to enter text.

**5. Checklist of Required Documents** (Attach with this application)

[ ] Proof of disability: **(Only the disability documents described below will be accepted)**

 [ ] Social Security Disability Determination (SSI/SSD Award Letter) or,

 [ ] NYS Department of Human Services Notice of Medicaid Disability DSS639

[ ] Receipt(s) or Invoices.

[ ]  **I have reviewed this application & I verify the beneficiary has a qualifying disability. I also have included all necessary documentation and I verify that:**

The beneficiary lives in the Greater Rochester/Finger Lakes region.

The beneficiary has not received a grant from the fund in the calendar year.

I understand the grant may be subject to tax and if the request is approved, the originating organization will receive a K-1 Statement on behalf of the beneficiary by March 15.

Community Professional’s Name & Title**:** Click here to enter text.

Community Professional’s Signature **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Organization: Click here to enter text.

Organization address (check will be made payable to this organization and mailed to this address): Click here to enter text.

Phone #: Click here to enter text. Email: Click here to enter text.

[ ]  **For Beneficiary: I have read the statement above and I understand the requested item must be for my SOLE benefit. I understand the grant may be subject to tax and the originating organization will receive a K-1 Statement on my behalf by March 15.**

**Beneficiary’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Return this form and documentation to:

B. Thomas Golisano Life Enhancement Fund

c/o Future Care Pooled Trust 1000 Elmwood Avenue, Suite 500, Rochester, NY 14620-3098 Or, email to golisanofund@futurecareplanning.org Or, fax to 585-210-4048