**---------------------------------------For Office Use Only----------------------------------------**

Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Rejected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Check Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**-------------------------------------------------------------------------------------------------------------**

**1. Beneficiary Information Application Date** Click or tap to enter a date.

Name:Click here to enter text. SS # Click here to enter text.

Date of Birth:Click or tap to enter a date. Age: Click or tap here to enter text.

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

County Click here to enter text.

Does beneficiary receive SSI? Yes No

Does beneficiary have approved:

Medicaid Medicare Other health insurance

Does beneficiary have a supplemental needs trust: Yes No

If yes, please provide the Trust information and explain why it is not used for this request:

Click or tap here to enter text.

**Additional Beneficiary Information (Optional)**

Gender: Male Female Transgender Ethnicity: Click here to enter text.

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

**2. Disability Type: check all that apply**

Intellectual/developmental Epilepsy Cerebral palsy Neurological impairment Autism Traumatic brain injury Physical Mental health Other: Click here to enter text.

**Proof of Disability** The document must state the following: **This individual is entitled to Disability Benefits** and only the documents described below will be accepted. Check which document is attached:

Social Security Disability Determination (SSI/SSD award letter) or

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

A notice of the amount of Social Security income is not acceptable proof of disability.

A notice of acceptance for Medicaid is not an acceptable proof of disability.

**3. Please List Item(s) or Service(s) Requested:** Click here to enter text.

Total Cost of Item/Service as listed on purchase price document: $ Click here to enter text.

Total Amount Requested from the Fund not to exceed $500.00: $ Click here to enter text.

**4. Briefly describe how the requested Item(s)/Service (s) will enhance the Beneficiary’s life:**

Click here to enter text.

**Please attach proof of purchase price for the item(s)/ service (s) listed above.**

**Check which type of document is attached**. (information on vender letterhead)

Invoice Quote Training Receipt On-line Print-out Other

Note: if requesting a warranty or protection plan, please explain how the extra coverage would enhance the beneficiary’s life and attach justification. Click or tap here to enter text.

5.  **By signing below, I verify I have reviewed this application and the information entered on**

**the application is true and accurate. I also verify:**

* The beneficiary has a qualifying disability, meets the fund criteria and I have included all necessary documentation
* The beneficiary lives in the Greater Rochester/Finger Lakes region.
* The beneficiary does not live in a certified residential setting.
* 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 agency making the purchase will receive a K-1 Statement on behalf of the beneficiary by March 15. **Agency tax ID is required.**

Community Professional’s Name & Title: Please printClick here to enter text.

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

Agency Name: Click here to enter text. Agency Tax ID # Click or tap here to enter text.

Agency street address: Click here to enter text. City: Click or tap here to enter text.

Zip Code: Click or tap here to enter text. County: Click or tap here to enter text.

Phone #: Click here to enter text. Fax: Click or tap here to enter text.

Email: Click here to enter text.

**Beneficiary: I understand I must have a qualifying disability and the requested item or service must be for my SOLE benefit. I understand the grant may be subject to tax and the agency making the purchase on my behalf will receive a K-1 statement by March 15 next year.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6. Location where reimbursement will be sent if different from above**

**Agency Name:** Click or tap here to enter text. **Agency Tax ID** # Click or tap here to enter text.

**Attention:** Click or tap here to enter text.

**Street Address:** Click or tap here to enter text.

**City:** Click or tap here to enter text. **State:** Click or tap here to enter text.

**Zip Code:** Click or tap here to enter text. **County:** Click or tap here to enter text.

**Phone #** Click or tap here to enter text.

**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](mailto:golisanofund@futurecareplanning.org)

Or fax to 585-210-4048