B. Thomas Golisano Life Enhancement Fund
Future Care Community Third Party Pooled Trust Application

For Office Use Only

Received Date: _____ Approved Date: _____

Approved Amount: $_____ Approved Excess Amount: $_____

Rejected: _____ Note: _____

****To avoid processing delays and application being returned please answer all questions****

FBO: Client/ Beneficiary full first and last name: _____ Date: _____

1. APPLYING AGENCY CONTACT INFORMATION: (Please print)

Agency: _____ Tax ID#_____

Address: _____ City: _____

Zip Code: _____ County: _____ Phone #: _____

Email: _____

Submitted By: (Print Name and Title) _____

ATTACH ONLY THE REQUIRED DOCUMENTS AS DESCRIBED BELOW

2. REQUIRED DOCUMENTS

Proof of Disability: Proof of disability determination has been made by the Social Security Administration or the New York State Department of Human Services is required. **Only the documents described below will be accepted**.
Check which document is attached:

_____ **Social Security Disability Determination**: SSI/SSD award letter or disability verification letter.

_____ **NYS Dept. of Human Services (DHS) MEDICAID Disability Determination**;(OHIP-0040, OHIP-00405, DSS-4141, or LDSS 4141 OR Disability review Team Certificate (DSS-630, or LDSS-630).

Please note the following documents are NOT acceptable:

1. **Social Security Income or Notice of Decision Letters**
2. **OPWDD Eligibility Letters**

3. BENEFICIARY INFORMATION:

Name: _____ D.O.B: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

County: _____ Phone # _____ SSN # _____

Disability Type:

☐ Autism ☐ Intellectual/ Developmental ☐ Physical ☐ Cerebral Palsy ☐ Mental Health

☐ Traumatic Brain Injury (TBI) ☐ Epilepsy ☐ Neurological Impairment ☐ Other: _____

Does the Beneficiary have a Supplemental Needs Trust? ☐ Yes ☐ No (If yes, please provide the Trust information and explain why it is not being used for this request.) _____

Does the Beneficiary receive SSI? ☐ Yes ☐ No

List a minimum of three funding sources previously explored and the outcome of each: **(Do Not list N/A in this section).**

Funding Source:	**Outcome:**

4. REQUEST INFORMATION: List the item(s) or Service(s) being requested

Note: Protection Plans and warranties are not covered through this fund. If the request is for an electronic device, please include an explanation as to how the device is connected to the beneficiary's disability and how it is intended to enhance the beneficiary's quality of life.

List Requested Item(s):	**List Price or Cost of Each Requested Item:**

Briefly describe how the requested items/services will enhance the Beneficiary's life: (4 sentences or less)

Check which document is attached to the application:

Invoice/Quote: _____ Online Printout: _____ Other: _____

PRICE $_____ Tax $_____ Shipping/Handling: $_____Total Cost: $_____

Note: If the total cost exceeds the $500.00 funding cap, please explain how the remainder will be paid below.

ADDITIONAL BENEFICIARY INFORMATION: (Optional)

Gender: Male _____ Female: _____ Transgender_____

Ethnicity: _____

Name of Caregiver: _____ Relationship: _____

DECLARATIONS

- The Beneficiary is age 18 or older.
- The Beneficiary has a qualifying disability
- 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 this calendar year.
- The Requested item has not previously been paid for by another person or entity.

I have included all required documents and verified that the information entered into this application is accurate. *I HAVE REVIEWED THIS APPLICATION. I VERIFY THE BENEFICIARY HAS A QUALIFYING DISABILITY AND INCLUDED ALL NECESSARY DOCUMENTATION. THE BENEFICIARY LIVES IN THE GREATER ROCHESTER/FINGER LAKES REGION. THE BENEFICIARY HAS NOT RECEIVED A GRANT FROM THE FUND IN THIS CALENDAR YEAR AND THE REQUESTED ITEM HAS NOT ALREADY BEEN PURCHASED AND PAID FOR BY ANOTHER PERSON OR ENTITY. I UNDERSTAND THE AWARD MAY BE SUBJECT TO TAX AND IF THE REQUEST IS APPROVED, THE BENEFICIARY WILL RECEIVE A K-1 STATEMENT BY APRIL 15.

Community Professional Signature: _____ **Date:** _____

Print or Type Name and Title: _____

Beneficiary: I understand I must have a qualifying disability, and the requested item/ service must be for my **SOLE** benefit. I understand this gift may be taxable and I will receive a K1 statement from Future Care Planning Services before April 15 next year for tax purposes. I consent to this application being submitted on my behalf.

Beneficiary Signature if able to sign: _____ **Date:** _____

If other than beneficiary, please check the appropriate relationship: Parent ____ Guardian ____ Advocate _____

The location where reimbursement should be mailed if different from Agency Information listed

Agency: _____ Attention: _____
Address: _____ City: _____ Zip Code: _____

Please return this application to:

B. Thomas Golisano Life Enhancement Fund
Future Care Community Pooled Trust
1000 Elmwood Avenue, Suite 500
Rochester, New York 14620-3098

Or email to: golisanofund@futurecareplanning.org or Fax: 585-210-4048