



B. THOMAS GOLISANO LIFE ENHANCEMENT FUND APPLICATION

For Office Use Only

Received: _____ Approved: _____
Amount Approved: \$ _____ Amount in Excess of Funding Cap: \$ _____
Rejected: _____ NOTE: _____

To avoid application being returned or delays, please answer all questions

FBO: (client/beneficiary) _____ Date: _____

1. AGENCY INFORMATION

Agency: _____ Tax ID#: _____
Address: _____ City: _____
Zip Code: _____ County: _____ Phone #: _____
Fax: _____ Email: _____
Submitted by: (print/type name & title) _____

ATTACH ONLY THE REQUIRED DOCUMENTS AS DESCRIPTION BELOW

2. REQUIRED DOCUMENTS

PROOF OF DISABILITY: Proof that a disability determination has been made by the Social Security Administration of the 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, a disability benefit verification letter or other letter from the Social Security Administration stating the benefit received is because the individual is disabled.
Medicaid Disability Determination: (OHIP-0040, OHIP-00405, DSS-4141 or Idss-4141 OR Disability review Team Certificate (DSS-630 or LDSS-630) from NYS Department of Human Services

Please note the following documents are NOT acceptable:

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



B. THOMAS GOLISANO LIFE ENHANCEMENT FUND APPLICATION

3. BENEFICIARY INFORMATION

Name: _____ D.O.B. _____ Age: _____
Address: _____ City: _____ Zip Code: _____
County: _____ Phone #: _____ SS#: _____

Type of Disability

_____ Autism _____ Intellectual/developmental _____ Physical
_____ Cerebral Palsy _____ Mental Health _____ Traumatic brain injury
_____ Epilepsy _____ Neurological impairment _____ Other _____

Does 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.

Additional Beneficiary Information: (Optional)

Gender : M _____, F _____, T _____ Ethnicity : _____

Name of Caregiver : _____ Relationship : _____

4. REQUEST INFORMATION: List the Items or Services you are requesting:

NOTE: Protection plans, and warranties are not covered

Items/Service	Price

Briefly describe how the requested items/services will enhance the Beneficiary's life:

PROOF OF PURCHASE PRICE: Check which document is attached

Invoice/quote _____ training receipt _____ online printout _____ Other _____

PRICE \$ _____ Est. TAXES \$ _____ S&H if applicable \$ _____ Total Cost \$ _____

TOTAL AMOUNT REQUESTED: (not to exceed \$500.00) \$ _____



B. THOMAS GOLISANO LIFE ENHANCEMENT FUND APPLICATION

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

DECLARATIONS

- 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 in this calendar year.

I have included all required documents and I verify the information entered on this application is accurate.

Community Professional Signature: _____

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 prior to April next year for tax purposes. I consent to this application being submitted on my behalf.

Signature: _____ Date: _____

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

Location where reimbursement should be sent if different from Agency information listed

Agency: _____ Attention: _____

Address: _____ City: _____ Zip Code: _____

Return this form and documentation to:
B. Thomas Golisano Life Enhancement Fund
 Future Care Trust Services
 1000 Elmwood Avenue Suite 500
 Rochester, NY 14620-3098

Or email to golisanoofund@futurecareplanning.org Or fax to 585-210-4048