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 ldss-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

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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. ONE ITEM PER LINE. Tab to the next line.	Price

Describe how this request will enhance the Beneficiary's life: Type ONLY to line end. Tab to next line.

_____

_____

_____

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) ..... $ _____

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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 golisanofund@futurecareplanning.org Or fax to 585-210-4048