B. THOMAS GOLISANO LIFE ENHANCEMENT FUND APPLICATION

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

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

1. AGENCY INFORMATION

Agency: _____ Tax ID#: _____
Address: _____ City: _____
Zip Code: _____ County: _____ Phone #: _____
Fax: _____ Email: _____

Submitted by: (print/type name & title) _____

FBO: (beneficiary) _____ Date: _____

To avoid application returns and delays, please answer all questions and attach ONLY the required documents as described below.

2. REQUIRED DOCUMENTS

PROOF OF DISABILITY: Proof that a disability determination has been made by the Social Security Administration or the Department of Human Services is required. Only the documents described below will be accepted. **A notice of the amount of Social Security income is not acceptable proof of disability.**

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-639 or LDSS-639) from the NYS Department of Human Services.

PROOF OF PURCHASE PRICE: Check which document is attached

invoice/quote _____ training receipt _____ online printout ____ Other _____

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3. BENEFICIARY INFORMATION

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

Address: _____ City: _____ Zip code: _____

County: _____ Phone #: _____ SS#: _____

Does beneficiary receive SSI: . . . . . Yes____ No_____

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 used for this request.

Additional Beneficiary Information: (Optional)

Gender: M_____, F_____, T_____ Ethnicity: _____

Name of caregiver: _____ Relationship: _____

4. REQUEST INFORMATION

List Requested Item (s) or Service (s:)

_____

_____

<u>Briefly</u> describe how the requested item (s)/service (s) will enhance the Beneficiary's life.

_____

_____

_____

_____

TOTAL COST: This dollar amount must match the purchase price document . . . . . $ _____
(Add tax and S&H if applicable)

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.

_____

_____

NOTE: If requesting a warranty or protection plan, please explain how the extra coverage would enhance the beneficiary's life and attach medical professional justification.

_____

_____

5. DECLARATIONS

The beneficiary named on this application meets all of the following qualifications:

- 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 above

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

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