B. THOMAS GOLISANO LIFE ENHANCEMENT FUND APPLICATION

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

Received: ___________________________ Approved: ___________________________________

Amount Approved: $_________________ Amount in Excess of Funding Cap: $______________

Rejected: ___________________________ NOTE:_______________________________________

1. AGENCY INFORMATION

Agency: ___________________________________ Tax ID#: ___________________________

Address: __________________________________ City: ______________________________

Zip Code: ______________ County: ________________ Phone #: ______________________

Fax: ________________________________ Email: _____________________________________

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

FBO: (client/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. 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.

Please do not submit documents that are NOT acceptable:

- Social Security Income or Notice of Decision Letters
- 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 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 warrantees are not covered.

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 _____________________

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.

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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 Agency Information above

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