GRANT APPLICATION

Date: ____
Participant Name: ______________________________
Date of Birth: _________________________________
Address: _____________________________________
____
County: ______________________________________
Phone Number: ________________________________
Email: _______________________________________

Resides With: (Give names of those who apply with their employer information if applicable)
Mother: ______________________________________
Employer: ____________________________________
Address: _____________________________________
____
Phone: _______________________________________

Father: ______________________________________
Employer: ____________________________________
Address: _____________________________________
____
Phone: _______________________________________

Guardian: _____________________________________
Employer: ____________________________________
Address: _____________________________________
____
Phone: _______________________________________

Medicaid Number: ______________________________
Social Security Number: _________________________
Referral Source: _______________________________
____
____
Disability: ____________________________________
____
____

Siblings: List names, ages and disabilities (if any):
____
____
____

Pets: (Types and names)
____
____
____

Does applicant or siblings currently receive any services? Y N
If so, please list: _____________________________
____

Additional Information: __________________________
____
____

Primary Care Physician
Name of Physician: ____
Address: ____
Phone: ____

MEDICAL PROFILE
□ Seizures □ Drug Allergies (List drugs and what kind of reaction occurred in comments) □ Heart Problems
□ Vision Impairments □ Hearing Impairments □ Sensory Problems □ Breathing Difficulties □ Other ______________
Comments: ____
____
____
____
____

MEDICATIONS
Does this person need medications? □ Yes □ No (If yes, please list names, doses, times, and why prescribed)

Name of Medication	Dose	Strength	Time	Who Prescribed?	Why Prescribed?

____
____
Comments: ____
____
____
____
____

COMMUNICATION

What form of communication does this person use? □ Verbal □ Sign Language □ Assistive Device □ Nonverbal
□ Other ____
Comments: ____
____
____
____
____

BEHAVIOR

□ Friendly □ Enjoys Socializing □ Self Abusive □ Wanderer □ Enjoys Being Alone □ Other ___________________
____
____

Does this person have a Behavior Intervention Plan?	YES _____	NO _____
Does the Plan include physical and/or chemical restraints?	YES _____	NO _____
Does the person take medications for behavior management?	YES _____	NO _____
Is this person free from harm or threat from harm?	YES _____	NO _____
Were there any substantiated abuse/neglect/exploitation involving this person over the past year?	YES _____	NO _____
Were there any Accident/Incident Reports involving harm to this person over the past year?	YES _____	NO _____

Comments: ____
____
____
____

PRIVACY/FREEDOM OF MOVEMENT

Does this person have the right to privacy and freedom of movement? YES _____ NO _____
If no, what are the restrictions?
_____ locked doors to leave/enter; _____ door alarm(s); _____ side rails; _____supervision with hygiene;
_____ supervision with travel; _____audio/visual monitor
Why is this restriction in place?
____
____

Is this restriction part of a Behavior Intervention Plan? YES _____ NO _____
If this is a restriction, what is the plan to reinstate this right?
____
____

MOBILITY

Does this person have the ability to move him or herself? □ Yes □ No
If yes, how? □ Ambulatory/Needs No Assistance □ Ambulatory/Sometimes Needs Assistance (Please explain in comments)
□ Crawls □ Non-Ambulatory/But Able To Transfer Self □ Other____
Is there any equipment needed in their assistance with mobility? □ Yes □ No
If yes, what type? □ Walker □ Wheelchair □ Braces □ Other ____

Comments: ____
____
____
____

EATING

□ Feeds Self □ Needs Assistance (Please describe what type of assistance in comments)
What kinds of foods can or does this person eat? □ Eats Solid Food □ Blended Food □ Mashed Food □ Baby Food
□ Finger Food □ G-Tube Food □ Bottle Fed □ Other ____
Does this person have any food allergies or food difficulties? If so, please explain. _____________________________
____
____
____
Comments: ____
____
____

BATHING

How often? ____
What type of bathing? □ Bath □ Shower □ Sponge Bath □ Other ____
Does this person need assistance? □ Bathes Self □ Needs Assistance
If this person needs assistance, please explain how much? ____
____
____
Comments: ____
____
____
____
____

TOILETING

Does this person need assistance? □ Yes □ No
If yes, what type of assistance? □ Reminders □ Needs Full Assistance □ Wears Diapers □ Other___________________
Comments: ____
____
____
____
____

RECREATIONAL ACTIVITIES

Please list activities this person enjoys below.
Comments: ____
____
____
____

VOCATIONAL/JOB

Name of Job/Occupation ____

How is this person compensated for labor he/she does? Salary ____ Hourly ____ Other ____

Comments: ____

____

____

____

GUARDIANSHIP

Does the person have a guardian? YES ____ NO _____

If Yes, please note the following: Full Guardianship _____ Limited Guardianship _____

If Limited Guardianship, please select the areas:

_____ Financial; _____ Medical; _____ Legal; _____ Voting; _____Residential/Vocational/Educational

Is this guardianship the least restricted and most appropriate and why?

____

____

____

If not, what is the plan to change this?

____

____

____

FINANCES

Does this person have control over all his/her finances? YES _____ NO _____

If no, what is the restriction(s)?

_____ Has a representative payee: ____ (Name of Payee)

_____ Has a dual signature on checks

_____ Checkbook retained by someone other than the person: _____ family; _____ agency; _____ other____________

Why is this restriction(s) in place?

____

____

____

What other alternatives to giving this person more control over his/her finances were considered and rejected?

____

____

____

If this is a restriction, what is the plan to reinstate this right?

____

____

____

FREEDOM OF EXPRESSION

Does this person have the same freedom of association and freedom of expression as other citizens? YES _____ NO _____

If no, who is restricted from associating with this person (note if there is a restraining order)?

_____ family member(s); _____other people in the community; _____voicing opinions freely and without fear of retaliation;

_____ accessing own records; _____filing grievances; _____belonging to groups/organizations (i.e. political/religious/social)

_____ other ____

Why is this restriction in place?

____

____

____

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If this is a restriction, what is the plan to reinstate this right?
____
____
____

PERSONAL PROPERTY
Does this person have the right to receive, possess, and use lawful personal property? YES _____ NO _____
If no, what item(s) are restricted?
_____hygiene supplies; _____food; _____bikes/motor vehicles; _____clothing; _____stereo equipment, radio, headsets, etc.;
_____ other ____
Why is this restriction in place?
____
____
____
If this is a restriction, what is the plan to reinstate this right?
____
____
____

Do you have a will? YES NO Do you have a **living will** or a **health care power of attorney**? YES NO
Do you have a DNR (Do Not Resuscitate)? YES NO
Do you need assistance in obtaining one of the above mentioned documents? YES NO If YES, which document? ________

If this grant application is for **EQUIPMENT**, please complete the following:
(Examples of equipment funded include wheelchairs, wheelchair accessories, communication devices, van modifications, lift systems, etc.)
Type of Equipment Requested: ____

A doctor's referral or referral from a licensed practitioner is required for all equipment requests.
Also required is a 300 word document explaining how the equipment will benefit the applicant and where the equipment will be used, i.e., school, home, or in the community.

Cost of Equipment Requested ___________
Other Funding ___________ Name of Funding Source ______________________________
Grant Amount Requested ___________

If this grant application is for **HOME MODIFICATIONS**, please complete the following:

Type of Home Modification Requested: ____
(Examples of home modifications include bathroom modifications, ramps, widening doors, lowering counters, etc.)

A proposal from a licensed contractor is required for all home modification requests. The proposal must indicate the supplies and labor costs for the modification requested.
Also required is a 300 word document explaining how the home modification will benefit the applicant.

Cost of Home Mod Requested ___________
Other Funding ___________ Name of Funding Source ______________________________
Grant Amount Requested ___________

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If this grant application is for **THERAPY**, please complete the following:
(Examples of therapy funded are OT, PT, SLP, Horseback Therapy, Water Therapy, Music Therapy, ABA Services)

Type of Therapy Requested: ____
Is applicant currently receiving type of therapy requested? YES NO
If YES, how often is therapy being received: ____
Name of therapist providing service: ____

A doctor's referral or referral from a licensed practitioner is required for all therapy requests. If the request is for additional therapy hours, the referral must indicate the reason for the additional hours and indicate the benefit to the applicant. Also required is a 300 word document explaining how the therapy will benefit the applicant, where the therapy will be provided, and who will provide the therapy.

Cost of Therapy Requested ___________
Other Funding ___________ Name of Funding Source ______________________________
Grant Amount Requested ___________

Any other comments you would like to make to help us better meet your needs: _________________________________
____
____
____

<u>If grant dollars are awarded, I will ensure all funds received are utilized according to requests made and instructions provided by the Team Daniel Foundation. I give Team Daniel Foundation consent to mail, email, or fax my (or son/daughter's) PHI (Protected Health Information) as related to this request.</u>

____ _______________________________
Applicant/Legal Guardian's Signature **Date**

____ _______________________________
Team Daniel Foundation Representative Signature **Date**

If you are not registered to vote, would you like to do so today?
Already registered ______; Yes, I would like to register ______

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