Request for Assistance Application - Tier 2

When complete, please submit applications by either:

1. Scanning and emailing to info@desatnickfoundation.org
2. Mailing to the Desatnick Foundation, 1001 Lafayette Street, Cape May NJ 08204

THE DESATNICK FOUNDATION

Request for Assistance Application

Tier 2

Use this application for grant requests above $2500.00

Thank you for contacting The DeSatnick Foundation ("The Foundation"). The Foundation intimately understands the sometimes overwhelming challenges that one faces when they, or someone in their family, suffers a spinal cord injury ("SCI"), as some of our very own board members are far too familiar with many of the challenges you are now likely facing. We sincerely hope we can provide some assistance for you and/or your family during this difficult time. To that end, we ask that you please carefully review the instructions below so that we can consider your request for assistance (applications are reviewed on a rolling basis). The Foundation wishes you all the best support and guidance during this journey. If you have any questions about the application process, before or after you submit the form, please do not hesitate to contact us at info@desatnickfoundation.org.

Instructions:

1) The Foundation provides financial grants to individuals currently affected by a SCI to offset the costs of treatment, help pay expenses and help replace some of the lost income due to the injury. In accordance with The Foundation's Bylaws, at least one of the following criteria must be met for an applicant to be eligible to apply for and possibly be awarded a grant: (1) the SCI must have occurred in Cape May, Cumberland, Atlantic, Ocean or Monmouth County, NJ; or (2) the applicant must be a permanent resident of one of the NJ Counties listed above.
2) The Foundation uses this application to review each applicant's individual case and allow for comprehensive consideration for assistance for those who have suffered a SCI. **PLEASE MAKE SURE THIS APPLICATION IS FILLED OUT COMPLETELY AND AS THOROUGHLY AS POSSIBLE. BE SURE TO INCLUDE COPIES OF ALL OF THE DOCUMENTS LISTED ON THE SIGNATURE PAGE AT THE END OF THIS APPLICATION.** Feel free to use additional pages to complete any answers to the questions in this application. If you do so, please indicate on the additional pages the section and item number the additional information being supplemented. If the application is not filled out completely, or supporting documents are not included, an applicant runs the risk of being denied assistance. Please complete the application with as accurate answers and information as possible. If you choose to submit a paper copy of the application, (a) please print legibly in blue or black ink and (2) send the completed application and supporting documents via regular mail to The DeSatnick Foundation, 1001 Lafayette Street, Cape May, New Jersey, 08204. If you choose to submit the application electronically, please follow the instructions provided on the Foundation's website (www.desatnickfoundation.org). Upon The Foundation's receipt of the initial submission, you will be sent an email confirming it's receipt.
3) Please make sure that the applicant completes the application. If this is not possible due to physical limitations, please have the applicant's designated representative (i.e., Power of Attorney, Health Care Surrogate, Legal Guardian and/or Spouse, etc.) complete the application. In that case, please include a copy of the document giving that person authority to complete and submit the application. Also, please make sure the application is notarized on the last page (i.e., the signature page).
4) In these difficult times, many people are dealing with severe economic hardship. Unfortunately, this can occasionally prompt someone to take desperate measures and perhaps even illegal or improper acts. Consequently, in order to preserve The Foundation's integrity and the trust of our many benefactors, the Foundation may: (a) perform legal background checks; (b) undertake a thorough medical review that might involve each applicant having their physician(s) fill out a medical overview form; and (c) request additional financial information. Please do not take offense to this, as it is an essential component for the continued viability of The Foundation, so that The Foundation's supporters and the community-at-large have on- going faith in our organization to properly screen our applicants and grant recipients.

5) Except as set forth in the next sentence, an approved applicant may only submit one (1) application every 12 months. An approved applicant may apply for one additional grant no sooner than 6 months after the initial grant is approved subject to the applicant demonstrating severe hardship.

6) Lastly, The Foundation wishes that it could grant assistance to all applicants, but this is simply not possible due to funding limitations and certain restrictions within its by-laws. If we are unable to provide you with assistance, please understand that we do so with regret.

What is the grant amount you are seeking? ___________________________

If approved by The Foundation, for what purpose will the grant be used? _____________________________________

____

____

____

SECTION A: APPLICANT INFORMATION.

1. Name of Applicant ____
2. Date of Birth____
3. Marital Status____
4. City____, State, Zip Code ____
5. Phone Number ____
6. Fax Number ____
7. E-Mail ____
8. Name of Spouse/Significant Other (If neither, please list next of kin) ________________________________
____
9. Contact Person Name & Phone Number____

SECTION B: MEDICAL INFORMATION

1. Describe the extent of the injury, the date it occurred and where it occurred (use additional pages if necessary). __

____

____

____

____

____

2. What is the applicant's current medical status and prognosis (e.g., level of injury)? Please list any comorbidities (i.e., any other physical or emotional issues, aside from your injury).

____

____

____

____

____

____

3. Describe the expected/current treatment (e.g. occupational therapy, physical therapy, future surgeries, home care etc.).

____
____
____
____
____
____

SECTION C: FINANCIAL INFORMATION

1. Do you currently have medical insurance? Y / N (circle one)
2. If yes, please identify the Health Insurance Company, coverage including deductible and/or co -pay requirements.

____
____

3. What are the monthly health care costs (including, but not limited to co-payments, travel expenses, alternative treatments, etc.) related to the SCI not covered fully or partially by insurance? ______________________

____
____
____

4. Are you currently employed Y / N (circle one)? If yes,
   a. Employer Name ______________________________
   b. Phone ________________________
   c. Address ____
   d. Job Title __________________________________
   e. Hours Per Week _____
   f. Average Weekly Income _______________________
5. Is your spouse/domestic partner currently employed? Y / N (circle one). If yes,
   a. Employer Name ______________________________
   b. Phone ________________________
   c. Address ____
   d. Job Title __________________________________
   e. Hours Per Week _____________
   f. Average Weekly Income ________
6. Current Balance of Checking Accounts $_______________. (Please include all accounts held by you, in trust for you or jointly by you and another).
7. Current Balance of Savings Accounts $________________. (Please include all accounts held by applicant, jointly by applicant or held in trust in which applicant is the beneficiary).
8. List all accounts, stocks, bonds, etc in which you a financial interest if not included in items 6 and 7 above, and indicate the current values of each.

____
____
____
____

9. Please list all forms of public assistance and amounts received.

____
____
____

10. Please list all public assistance applications pending and provide status of applications. ____________________
____
____
____

11. Please list forms of public assistance denied and basis for denial.
____
____
____

12. Have you ever applied for or received a grant from any other charitable foundation? *Y / N (circle one)*
13. If yes, please indicate (for each):
    a. Foundation name _______________________________
    b. Date of Application _________________________
    c. Amount received (if awarded) __________________
    d. Reason for Denial (if denied) _____________________________________
14. Please list all current sources of household income or financial support not listed above in this section of the application. For example, this may include, but not be limited to, family assistance, "GoFundMe" or similar accounts, or community assistance.
____
____
____
15. Please list current monthly bills (i.e., mortgage, phone, credit cards, etc.) ______________________________
____
____
____

SECTION D: ADDITIONAL INFORMATION

1. Please list any and all social support systems (e.g., support groups, friends, family members, counselor(s), therapist(s), psychiatrist(s), church group/support, etc.) that are helping the applicant during this difficult time.
____
____
____
2. Is your spouse/significant other able to be supportive of your care/treatment? Yes / No (Please circle one)

3. How did you hear about The DeSatnick Foundation?
____
____

4. Please list 3 references (one professional and two personal)
    Name_______________________________Phone_______________________________
    Name_______________________________Phone_______________________________
    Name_______________________________Phone_______________________________
5. Have you ever been convicted of a crime involving dishonesty, fraud or deceit (if yes, please explain)?
____
____

6. Do you give The Foundation permission to perform a legal background check?
   Yes / No (please circle one). *Please note that if you grant permission to perform such a check, you agree that if requested, the Applicant's social security number will be provided if necessary.*
   IF YOUR RESPONSE IS YES, PLEASE INITIAL HERE. _______________
7. Do you give The Foundation permission to contact the physicians or other medical personnel providing care and treatment?
   Yes / No (please circle one)
   IF YOUR RESPONSE IS YES, PLEASE INITIAL HERE. _________________
8. Please provide the names, addresses and phone numbers of physicians or medical personnel The Foundation may contact according to the affirmative response above.
   ____
   ____
   ____
9. Please describe any additional factors you feel are relevant to this application. _________________________
   ____
   ____
   ____
   ____

SECTION E: SUPPORTING DOCUMENTS / SIGNATURE (THIS PAGE MUST BE NOTARIZED)

1. **Please review your application and include the following documents, if applicable, with this application**:

   1. Copies of the most recent federal income tax form (if Applicant and spouse/domestic partner file separately, then include copies of both returns).
   2. Copies of two most recent paycheck stubs for applicant and spouse/domestic partner. .
   3. Copies of two months bank statements.
   4. A copy of applicant's driver's license.
   5. A copy of applicant's health insurance card.
   6. A notarized letter from applicant's current physician stating that you are under their care for a spinal cord injury.
   7. Fill out and return with the application the included HIPPA disclosure form.

   Applications that do not have these documents will not be considered for assistance. Any questions you may have can be emailed to info@desatnickfoundation.org

Signature

I certify that the facts contained in this application are true and correct. I have made these statements in an effort to obtain financial assistance. (**sign in front of notary and to get official stamp/notarized)**.

____________________________ __________
Signature Date

____
Print Name Above…………………………………………

Sworn and subscribed to before me, a
Notary Public of the State of _____________
And County of ________________ this _____
Day of _______________, 20__.

Stamp/Seal of Notary

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: ___________________________________
Street Address: __________________________________
Date of Birth: ___________________________________

I hereby authorize: ____ (Name of physician's office/ medical practice disclosing information) to disclose the information indicated below to

The DeSatnick Foundation
Attn: Chad DeSatnick
1001 Lafayette Street
Cape May NJ 08204

Patient: Please indicate the information or types of information to be disclosed:

____ *Hospital records (photostatic or otherwise) including medical history, consultations, prescriptions or treatment, x- rays, etc.*

____ *Reports from doctors who have treated or examined me.*

Specify Dates (or date ranges) if applicable:

This request is for the purposes of: Application for financial assistance

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above facility authorized to make this disclosure. I understand that the revocation does not apply to the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire at the conclusion of my worker's compensation claim.

I understand that any disclosure of information may be subject to re-disclosure by recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INITIAL HERE: _________.

Signature of Patient **Date**

____ ________________