

Bridge2Hope Day Program Grant Application

It is an expectation of Bridge2Hope that any grant recipient, who is a full SSI beneficiary, pays at least \$449.34 per month toward his/her programming costs. By filling out and submitting an application for a Bridge2Hope Day Program Grant, applicant is acknowledging and agreeing to this expectation.

Please note that all grants issued through Bridge2Hope are subject to the availability of funds.

Applicant Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____ City/State/County: _____

Zip code: _____ Phone: () _____ Date of Birth: _____

Place of Birth _____ Sex: _____ Social Security Number _____

Primary Disability _____ Secondary Disability _____

Pertinent medical diagnoses (if any) _____

Does applicant have a guardian? Y _____ N _____

Guardian Information: Please submit copy of guardianship documentation.

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Street Address: _____ City/State: _____

Zip code: _____ Phone: () _____ Alternate Phone: () _____

Applicant must meet all of the following criteria.

Please attach supporting documentation. (Copies of SSI and Medicaid award letters, most recent copy of PUNS annual review, Medicaid waiver/ DHS application or letter of denial, if applicable.)

Active in PUNS database in Emergency or Critical needs

PAS agent name and contact number _____

Social Security Income recipient: Is recipient receiving the full SSI benefit? Y _____ N _____

If no, please contact Executive Director at 708-710-4321

Medicaid recipient (Medical): Medicaid ID number _____

Elim Christian School student or recent graduate: Month/Year of graduation: _____

Applied for and has been denied Department of Human Services Medicaid Waiver Funding for adult services, or has not been allowed to apply for funding due to new DHS criteria but would normally have been eligible to apply.

Please respond to the following questions. Attach additional sheets if necessary.

Bridge 2 Hope

- 1) What will receiving this grant mean to my child?**

- 2) What will receiving this grant mean to our family?**

- 3) Have any alternate plans for programming been explored?**

- 4) What is my child's greatest strength and greatest weakness?**

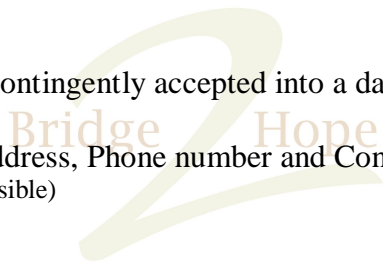
- 5) What measures have already been taken by guardian to secure DHS funding to date?**
(Please provide any documentation.)

- 6) Have any alternate funding sources been explored?**
(Please provide any documentation)

- 7) If approved for grant, what additional measures might you take to obtain funding?**

- 8) What was your child's attendance record in school?**

I authorize a B2H representative to access my child's attendance records at Elim Christian School. _____
- 9) If frequent absences occurred, what was the reason?**



1. Has applicant applied for and been contingently accepted into a day program? Y ____ N ____
2. Program Service Provider Name, Address, Phone number and Contact name:
(Attach documentation of acceptance if possible)

3. Do you have a secondary choice of service provider in the event that a change in placement needs to occur?
Y__N__ Service Provider:_____
4. Has guardian discussed private pay rate with potential provider? Y____N____
If yes, yearly private pay cost of program \$_____
5. At this time, what type of program placement is the best fit for applicant? Why?
Workshop ____ Vocational Training ____ Developmental Training ____

6. Is applicant independent in self-help skills? Y ____ N ____
7. What type of self-help assistance does applicant require? _____

8. Does applicant require the use of a 1:1 aide within the classroom? Y ____ N ____
9. What is the purpose of the aide? _____
10. If an aide is present, what attempts have been made to lessen the dependence on 1:1 support?

11. Has applicant participated in a job-training program? Y ____ N ____
If yes, please submit a copy of the final report from program
12. Will the applicant have transportation needs for above program? Y____N____
Bridge2Hope Day Program Grant does not cover transportation costs
13. If yes, what measures are being taken to address this need?
14. Has grant applicant applied for ADA Paratransit Service for transportation needs? Y____N____
(If no, please call 1-312-663-4357 and ask them to mail you an application.)



I declare that the statements made on this application are true and correct; I have not knowingly or willfully made false statements or included false documents in support of this application; I have read and understood the confidentiality statement.

Applicant: _____

Guardian: _____

Date: _____

Board Approved 1/21/2010