

# Bridge2Hope Day Program Grant Application

*It is an expectation of Bridge2Hope that all grant recipients, who are full SSI beneficiaries, pay the first \$449.34 per month toward day 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 \_\_\_\_\_

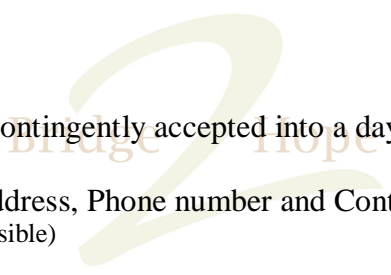
I am a recent or impending graduate of school age programming and in need of transitioning into adult service programming.

I have applied for and been denied Department of Human Services Medicaid Waiver Funding for adult services, or I have 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. School name \_\_\_\_\_  
Signature \_\_\_\_\_
  
- 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