Charitable Grant Program Application

Return the application with required documents to:

Midwest Special Needs Trust
P.O. Box 7629
Columbia MO 65205
Email: grants@midwestspecialneedstrust.org
Phone: (573) 256-5055

ELIGIBILITY

1. You must be a Missouri resident.
2. You must have a disability that is verified with a ***Social Security Verification Letter***.
3. You must meet the income guidelines listed below. The yearly gross household income[1] cannot go over the following 2023 Federal Poverty Guidelines:

Persons in Household	Maximum Income	Persons in Household	Maximum Income
1	$14,580	5	$35,140
2	$19,720	6	$40,280
3	$24,860	7	$45,420
4	$30,000	8	$50,560

If you do not meet all of these qualifications, you are not eligible to apply for a grant.

Please Note: Applicants who meet the qualifications are not guaranteed a grant.

GRANT AMOUNT

The maximum grant amount is $2,000. Grant decisions are based on the amount shown on the estimate or treatment plan. You may only receive one grant in a 12-month period of time.

TYPES OF GRANTS

General Grants: These funds are available to help with needs not covered by insurance, public benefits or available through other community programs.

Urgent Care Grants: These funds are available for urgent medical and dental needs requiring more immediate intervention.

TYPES OF ASSISTANCE NOT PROVIDED

Grants will not be awarded for any need that is met before the grant is approved. The grant will ***not*** assist with vehicle repairs, vehicle purchases or home repairs. Specific disability related modifications or accommodations will be considered. Only furniture needs specifically disability related will be considered. This grant is not available for food, cash, rent, mortgage payments or room and board expenses such as taxes, insurance, utilities and moving.

GRANT AWARD PROCESS

Applications may be submitted at any time. **General Grant** awards are made once each month. **Urgent Grant** awards are made twice each month.

Applicants and agency representatives will receive a letter in the mail after the review. Award decisions will not be shared over the phone.

GRANT PAYMENTS

All payments are made by check. Payment will be made only to the business listed on MSNT's authorization form.

[1] Yearly Gross Income is the amount of money a household receives in one year before any deductions. This includes income from all sources.

Please keep this page for your records.

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APPLICATION PROCESS

To be considered for a grant the application must be complete, accurate and sent with the following information:

- Proof of all gross income received by the applicant. This must include a current copy of the SSI and/or SSDI award letters from Social Security. This letter needs to state the monthly amount(s) received and show that the applicant receives disability benefits. Proof of all wages, child support, retirement income, etc., must be sent as well.
- Proof of gross income for everyone else living in the home, no matter the age of the person or the relationship.
- An estimate. Estimates must be a letter from the business and include a list of the items needed and the exact cost of each one. It also needs to include the name and contact information for the business.
  - For dental needs, the estimate must be a treatment plan from a dental provider.
  - For hearing aid and eyeglasses requests, you must send a copy of the evaluation.
  - For medical equipment, exercise equipment, communication devices, lift chairs and monitoring systems requests, submit a letter of recommendation from a licensed professional. This will state why the item(s) is needed.
  - For home modification requests, the estimate must be from a licensed contractor. The applicant must provide proof of home ownership or a letter of approval from the landlord.

This application is for (check one)

☐ **General Charitable Grant**

☐ **Urgent Medical and Dental Grant**

Contact Information

Date: _____

1. Applicant Information

_____
First Name **Last Name**

_____
Mailing Address **Apt/Lot #**

_____
City **State** **Zip Code**

_____
Phone Number

_____
Email Address

2. Agency Representative (Not Required)

_____
First Name **Last Name**

_____
Organization

_____
Mailing Address

_____
City **State** **Zip Code**

_____
Phone Number

_____
Email Address

Applicant Background Information

3. Date of Birth: _____-_____-_____

4. Type of Disability:

☐ Mental Illness
☐ Physical Disability (Please specify) _____
☐ Developmental Disability
☐ Brain Injury
☐ Spinal Cord Injury

5. Living Situation: (mark all that apply)

☐ Lives Alone ☐ Lives with Spouse ☐ Lives with Children ☐ Lives with Parents
☐ Lives with Foster Parents ☐ Lives with Other; Describe_____
☐ Staffed apartment or assisted living facility
☐ Group home or residential treatment facility
☐ Nursing home
☐ ISL (Individualized Supported Living)
☐ RCF (Residential Care Facility)
☐ State-operated facility (specify) _____
☐ Other (specify) _____

6. Total number of people who live in the home:_____

7. Applicant receives the following monthly income(s):

☐ Supplemental Security Income $_____
☐ Social Security Disability Insurance $_____
☐ Social Security Retirement Benefit $_____
☐ Other income: Type _____ $_____
Type _____ + $_____

Total Monthly Income = $_____

☐ Food Stamps
☐ Medicaid
☐ Medicare
☐ Applicant receives no public benefits or has no income

8. List everyone else that lives in the home. List their monthly income:

_____ $_____
_____ $_____
_____ $_____
_____ + $_____

Total Monthly Income = $_____

9. Total from #7 $_____+ #8 $_____= $_____x12= $_____ Total (Gross) Yearly Income

✶ Please refer to the 2023 Federal Poverty Guidelines chart below to see if you meet the income qualifications. If your annual ***gross*** income is over these guidelines you do not need to continue with the application process.

Persons in Household	Maximum Income	Persons in Household	Maximum Income
1	$14,580	5	$35,140
2	$19,720	6	$40,280
3	$24,860	7	$45,420
4	$30,000	8	$50,560

10. Type of assistance requested:

☐ Medical and Dental Care and Equipment
☐ Rehabilitation Training, Services or Devices
☐ Supplemental Education Assistance
☐ Personal Goods and Services
☐ Specialized Transportation

Description of Request for Assistance

11. List the specific item or service that is needed:

_____

12. Describe the applicant's situation. Include why the item or service requested above is needed and how it will benefit the applicant. Please provide as much information as possible:

_____

_____

_____

_____

13. Amount Requested: $_____ (Maximum Grant is $2,000)

Name of business you wish to use: _____
Address:_____
Phone Number:_____

14. If the estimate is greater than $2,000, how will the remainder of the bill be paid?

_____

Outside Resources

15. What effort has been made to find help with this need from other agencies?

_____

Was the request denied? ☐ Yes ☐ No

What was the reason for denial? _____

Please Sign Below

By signing below, I attest to the truth and accuracy of all information provided in this application. I understand failure to provide accurate and complete information will result in denial of the request. I also understand I am not guaranteed a grant.

_____ _____
Applicant Signature **Date**

I certify by signing below that I have assisted the applicant to complete the application, and that the information provided is accurate. I understand failure to provide accurate and complete information will result in denial of the request. I also understand the applicant is not guaranteed a grant.

_____ _____
Agency Representative Signature (If applicable) **Date**

Application Completion

Before sending in the application, you must include **ALL** of the following documents.

☐ Copy of the applicants Social Security verification
☐ Proof of all income (for applicant *and* household members)
☐ Estimate or Treatment Plan

Please refer to Page 2 of the application to see if any of the following items are needed:

☐ Copy of Evaluation ☐ Letter of Recommendation ☐ Proof of Home Ownership

How did you hear about our Charitable Grant Program? _____