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 Indianapolis, IN 46278
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UNITED CEREBRAL PALSY ASSOCIATION OF GREATER INDIANA, INC.
 SPECIFIC ASSISTANCE GUIDELINES SUMMARY – Page 1 of 2

- * Requests for applications must come from the client/family either by telephone, e-mail, or website. Applications will be sent ONLY to client/family.
 - * All completed applications (including all required supporting documentation) will be reviewed on the first of every other month (February April, June, August, October, December).
 - * The Executive Director may approve, table or deny requests without committee review up to the total budgeted amount available each month for this purpose.
- All requests will be prioritized according to the type of device, its purpose and function.
- * Applicants will receive written notification of the decision of the Executive Director within seven (7) days of the decision.
 - a) if the request is approved, a copy of the written notice will be sent to the vendor authorizing billing;
 - b) if the request is tabled, an explanation of additional requirements will be included in the letter;
 - c) if the request is denied, an explanation of the reason for denial will be included in the letter; insofar as is possible, alternative funding sources will be suggested.
 - * Only monetary assistance will be provided/approved. All payments are to be made directly to the vendor of the applicant's choice. It is to be mutually understood that the applicant is the BUYER.
 - * The following scale will be applied to all requests:

<u>Adjusted annual income*</u>	<u>% of request (or capped limit)</u>
<150% Federal Poverty Level (FPL)	100%
150%<x<200% FPL	95%
200%<x<250% FPL	90%
250%<x<300% FPL	80%
350%<x<400% FPL	70%
>400% FPL	60%

*Based on the most recent Federal Poverty Level Guidelines

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SPECIFIC ASSISTANCE GUIDELINES SUMMARY - Page 2 of 2

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- * The following items shall be considered as the top priorities (in decreasing order) in terms of funding approval and every effort will be made to award the full amount requested, consistent with the financial eligibility guidelines above and as funds are available:
- a) primary mobility equipment (e.g. walkers, wheelchairs, crutches, etc.) – either the purchase or repair of the person’s primary mobility device
 - b) orthotic equipment (braces, canes, shoes, etc.)
 - c) augmentative communication devices, not including basic computers not used as a primary communication tool
 - d) other equipment (car seats, in-home portable lifts, positioning chairs, computer aids, etc.) will be considered if funds are available
 - e) back-up means of mobility (manual chair for use when power chair is not available or usable, stroller for easy transport in family car, etc.)
 - f) adapted sports/recreation equipment
 - g) camperships
- * Applications for the following will not be considered:
- a) home or vehicle modifications including ramps, lift systems, etc.
 - b) payment of medical or therapy bills or for ongoing treatment (e.g. Botox)
 - c) rental or purchase of equipment for which other funding is available
 - d) requests for retroactive funding
 - e) participation in other fund-raising efforts by any client
- * At the discretion and by a majority vote of the Program Committee, any or all of the above restrictions can be waived
- * All applicants will have the right to appeal the decision of the Executive Director within thirty (30) days of notification. Appeal hearings will be conducted by the Program/Service Committee within thirty (30) days of an appeal. The decision of the Committee is final.
- * Individuals whose applications have not been completed or withdrawn within three (3) months will be contacted by mail or email regarding the status of their request. Such communication shall include a statement that, if the applicant does not contact UCPAGI within ninety (90) days, the request will be withdrawn but that s/he is eligible to submit a new application at any time.

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SPECIFIC ASSISTANCE - APPLICATION FORM - Page 1 of 2

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Date of Application: ___/___/___ Client Name: _____

Diagnosis: _____

Medical Professional (Doctor, etc.) _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Address: _____

City/County: _____ ZIP _____ Telephone #: _____

Contact Name: _____ Relationship _____

Contact Address: _____

City/County: _____ Telephone #: _____

Email Address: _____

Client/Parent Employer: _____ Position: _____

Other Employer: _____ Position: _____

Service/Equipment Requested:

_____ Wheelchair: Manual Power Purchase Repair

Make/Model: _____ Year: _____

Description: _____

Intended use: Home School Work Indoor Only Outdoor

___ Campership: 1-week 2-weeks New camper ___ Years as camper

___ Diagnostic Services: Initial visit Follow-up Other (specify) _____

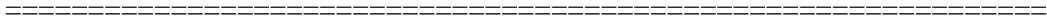
Other (specify): _____

Preferred Vendor: _____ Contact: _____

Vendor Address: _____ Phone: _____

UNITED CEREBRAL PALSY ASSOCIATION OF GREATER INDIANA, INC.

SPECIFIC ASSISTANCE - APPLICATION FORM - Page 2 of 2



Financial Information:

Total GROSS ANNUAL FAMILY* income: \$ _____

Total Dependents*: _____

(*Include ALL members of your household and ALL household income)

Total Amount of Item: \$ _____

Total Amount of UCPAGI request: _____ Total unmet need: \$ _____

Other Funding: None Insurance: \$ _____ Individual: \$ _____

Other (specify source and amount):

_____ \$ _____ \$ _____

Type of Insurance: Private: _____ Medicaid Medicare

- SSDI CHIP SSI Children's Special Health Care
- ICHIA SSDAC None Other: _____

Medicaid Waiver: (specify) _____

Extraordinary expenses or extenuating financial circumstances which may limit your ability to contribute to payment for this request or which should be considered in waiving the sliding scale or allowable amount for the item.

How will this service/equipment increase the individual's independence and quality of life?

I certify that I am a legally authorized signer of this application and understand that UCPAGI furnishes only financial assistance. I further certify that I understand there is no medical direction expressed or implied through this assistance by UCPAGI, its staff, volunteers, or representatives.

Signature: _____ Relationship: _____ Date: _____

UNITED CEREBRAL PALSY ASSOCIATION OF GREATER INDIANA, INC.
SPECIFIC ASSISTANCE - DOCUMENTATION CHECKLIST

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(Please submit, with your application, ALL documentation **highlighted** below)

1. For ALL requests

- _____ **Completed and signed application form**
- _____ **Proof of income** (copy of pay stub, SSI determination letter, tax return)
- _____ Picture of person requesting assistance, if available
- _____ **Written quotation/estimate from vendor** (including labor and related costs) (Please note: UCPAGI is a tax exempt organization)

2. For mobility equipment (wheelchairs, etc.) and Communication devices

- _____ Written **documentation of need** (prescription, individual education or program plan, note from therapist, etc.)
- _____ Proof of denial or partial payment by other sources

3. For Communication devices (for children only)

- _____ Documentation of compatibility with school-provided system

4. For vehicle modification/lift installation

- _____ Statement of soundness of vehicle and cost effectiveness (if a used vehicle)

5. For property modifications

- _____ Dimensional installation drawings; specifications (including materials)
- _____ Waiver by owner, if rental property

6. For camperships

- _____ Copy of camp application
- _____ Proof of denial or partial payment by other sources

7. Other:

- Funding for these items not currently available

Mail application to: United Cerebral Palsy Association of Greater Indiana
6270 Corporate Drive
Indianapolis, IN 46278

Or email to: mfoddrill@ucpindy.org