**REHABILITATION FOUNDATION OF NORTHWEST FLORIDA**

2929 Langley Avenue, Suite 202; Pensacola, Florida 32504 (850) 478-00297

**APPLICATION FOR FUNDING**

(TO BE FILLED OUT BY APPLICANT OR SPONSOR)

Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action: Date Denied /Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount /Days \_\_\_\_\_\_

For Foundation

Office Use Only

 1. Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_

 3. Where is applicant at this time? If not at home, give specific location. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Applicant’s Disability (i.e. quadriplegia, hemiplegia, amputee, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Date & Cause of disability (auto accident, diving, stroke, diabetes, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. Resulting Handicap(s)-) List normal things you cannot do): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 7. Purpose of request (i.e. inpatient or outpatient rehab; equipment-be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: (If for rehabilitation treatment, also complete M.D. Form)

 8. What results (improved function) would be expected if funding is approved? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9. Amount(s) Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Applicant’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TOTAL $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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11. Applicant’s present income & source(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 & Family income & source(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. List others in Household & ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Other Family & Location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Applicant’s education level & occupation(s) held: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Please indicate if applicant is a client of or receiving assistance (NOTE $ amount(s)) from:

State Voc. Rehab. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, VA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Medicare \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Medicaid \_\_\_\_\_\_\_\_\_\_\_\_\_\_, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any of the above noted resources pending? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any other sources possible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. Is litigation pending as a result of accident or injury? \_\_\_\_\_\_\_\_\_ if ‘yes’ describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Will repayment of funding be possible? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Applicant’s history (if any) problems/treatment for:

Alcohol Abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Use/Abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Person, Title, & Organization making request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**BUDGET**

 Monthly Annual

**FAMILY INCOME** $ \_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_

 From All Other Sources $ \_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_

 $ \_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_

 $ \_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_

 **TOTAL** $ \_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXPENSES**

House payment/Rent $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Car Payment $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Car Expenses (Gas & Maintenance) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Utilities (Water, Electric , Gas, Trash) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Life $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Health $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Car $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Etc. (renters,’ House) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cable TV/Internet $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Food $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Alcohol $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cigarettes $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medications $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Child Care $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other Payment(s) Specify: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **TOTAL $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REHABILITATION FOUNDATION OF NORTHWEST FLORIDA – (850)478-0297; FAX 478-1776**

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**REHABILITATION FOUNDATION OF NORTHWEST FLORIDA**

The Rehabilitation Foundation of Northwest Florida is a non-profit, charitable organization which was established for the purpose of awarding grants to the physically disabled who lack funds for rehabilitation services. In as much as the Foundation’s funds are limited, and the need is so great, it is our desire to extend those resources to benefit the greatest possible number of physically disabled.

Please carefully read and sign this agreement which will assist the Foundation in achieving this goal.

**NOTICE OF LIEN AND AGREEMENT OF RECIPIENT**

As a condition of my receipt of this grant from the Rehabilitation Foundation of Northwest Florida, I agree to the following terms:

1) In the event circumstances should otherwise change, whereby other funds become available by way of compensation for injury, third party reimbursement, Medicare, Medicaid, insurance, grant or gift from any source whatsoever, the Rehabilitation Foundation of Northwest Florida shall be relieved of any further financial obligation which might still remain under the grant made to me.

2) In the event that the Rehabilitation Foundation of Northwest Florida becomes entitled to recapture from some third party source the grant funds which have been expended, I will cooperate in any reasonable way called upon by the Foundation to recapture the grant funds.

3) Should I at any time after receipt of any or all of this grant make claim or file a suit to recover money damages against any person legally liable for causing the injuries which gave rise to my need for this grant, I agree to repay as much of the grant that has been received, to the extent that the recovery made by me by the claim or suit is sufficient to do so from the net proceeds received by me from the claim or suit. That is, the Foundation shall recover from the net proceeds, after attorney’s fees and cost incurred by the grant recipient have been deducted, 100% of what it has paid.

4) In the event that I, personally, no longer require the use of equipment purchased for my use by the Foundation, I agree to notify by telephone or in writing, the Foundation office so that said equipment may be returned to the Foundation as soon as possible so that other disabled persons may also benefit from its use.

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Recipient Signature Printed Patient/Recipient Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Recipient’s Representative Relationship to Recipient

**AUTHORIZATION FOR MEDICAL INFORMATION**

TO WHOM IT MAY CONCERN:

 This authorizes all physicians, hospitals and medical attendants to furnish full and complete medical reports and information hereby requested by the undersigned to The Rehabilitation Foundation of Northwest Florida employees and Board members, for an accident or illness which occurred on or about \_\_\_\_\_\_\_\_\_\_\_\_\_.

 This authorization also includes examination of all hospital records, x-ray films, and the furnishing of any information, including opinions, which will aid the Foundation in the evaluation of requests for grants made by your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Your full cooperation is requested. You are further requested to disclose no information to any other person(s) without written authority to do so.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Social Security Number)

Witnessed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

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**Substance Abuse Program Agreement**

I agree to seek and participate in a substance abuse program if I accept funding from the Rehabilitation Foundation of Northwest Florida.

I understand that no further funds will be provided if I do not attend such a program. Proof of attendance will be required for all additional requests.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be completed if there is a recent history of illegal drug use or substance abuse of any kind.

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