FOOTSTEPS of WNY

For Office Use Only

Date Received________________

File Number__________________

Footsteps of WNY Funding Application Form

The of funds from Footsteps of WNY, Inc to recipients will consist of the entire board reviewing the information provided on the application and the board members voting to award or deny the request. The vote must be a majority vote. Upon receipt of an application, information provided will be reviewed and verified, including: income documents, letters of denial for insurance coverage, any other sources of funding attempted, letters from physicians, therapists, or any other outside professionals involved in the applicant's care to assess the applicants need for assistance. However the majority vote of the board will not depend solely on the preceding information as other circumstances may apply. Companies and organizations that provide equipment or services needed by the applicant will be contacted for information on price and availability. Footsteps of WNY reserves the right to limit assistance on a per applicant basis so that we can better meet the needs of more individuals who require assitance.

With applications that are denied, a letter will be sent to the applicant regarding the board's decision. Applicants who wish to re-apply must provide additional documentation that the child or families circumstances have changed or that all other possible alternatives have failed

Note: Footsteps of WNY is only available to individuals with a medical diagnosis of some form of Cerebral Palsy. Please review the guidelines carefully before submitting your application

Applicant Information

Name of Primary Contact:____
(parent or guardian required if applicant is under 18) First Name Last Name

Relationship to Applicant:____

Address:____

City:____________________________ZipCode:______________

Telephone:__________________________

Email:____

Primary Contact (if applicable)

Name (who is the request for):____
First Name Last Name

Date of Birth:______________Diagnosis*_________________________________
***Medical Documentation Required: Attach Copies**

Address:____

City:____________________________ ZipCode:________________

Telephone:________________________ Email___________________________

Specific Equipment or Service Requested:____
(please provide exact name or attach description)

Estimated Cost of Equipment or Service: (Vendor Quote) $________________

Have you or will you receive any other funding from any
other organizations, friends or family? Yes___ No___

Please provide information regarding all steps taken to obtain equipment and/or services for the applicant (insurance requests, other organizations attempted, etc.)
Attach any explanations along with any letters of denial received

Please indicate any special circumstances you feel are pertinent to this request.
Attach a separate sheet if needed

____

____

____

____

Financial Disclosure (Place a Zero if none)

Annual Salary (If more than one care giver what are combined salaries? $________________
W2 Form Required. Attach Copy

Pension, unemployment, workman's comp. $________________

Social Security, S.S.I, Disability. $________________

Public Assistance $________________
Public Assistance Source_______________________________

Child Support $________________

Annual Gross Household Income including all sources $________________

Number of people currently being provided for on this income ________________

Applicants Health Care Coverage (Check All That Apply)

_______ No Health Care Coverage _______ Medicaid _______ Medicare

_______ Private (Specify)____

_______ Other (Specify)____

Is there a deductible Yes______ No______

If yes, what is the deductible $____________________

Checklist of Provided Information Pertaining to Request, Please Include

_______ A recent letter from the child's physician explaining the medical necessity and/or a letter from a health care professional explaining how the applicant would benefit from the equipment and/or service requested.
_______ A letter of denial from the applicant's insurance provider, which states that the equipment and or service was denied
_______ proof of all income. W2 Forms is Required. We keep all information confidential
_______ Any other documentation pertaining to the applicant or nature of request
_______ I understand that the above information is required. Applications that are not completed in full or missing requested additional information will not be reviewed.

Certification

I certify that the information provided in this application is true, correct and complete to the best of my knowledge.
By providing your signature below, as the applicant or applicant guardian, you are giving permission to Footsteps of WNY to process your application accordingly

Signature:_______________________________________ **Date:**______________

Relationship to Applicant:____

Please ensure all information and supporting documentation are provided. If any information is missing, the application will be returned for completion, resulting in a delay in processing the request. A copy of the completed form should be kept for your files.

By awarding finances, Footsteps of WNY is making no recommendation as to the appropriateness or safety of a particular piece of equipment, for each applicant. The Footsteps of WNY board is not responsible for the safety and the use of the equipment or the progress of the applicant. Each applicant and their guardian is strongly urged to consult with their physician and therapist regarding medical choices. Footsteps of WNY will only act as a third party payer for medically prescribed or medically necessary equipment or services

Footsteps of WNY will not divulge names or any other information on any applications or requests that we receive without written consent from the applicant or their legal guardian.