Colburn Keenan Foundation, Inc.

INDIVIDUAL ASSISTANCE GRANT PROGRAM

Before submitting your application and required documentation, be sure that **every** item listed below is included. **Missing information or documentation will delay the review of the application.**

CHECKLIST FOR SUBMISSION

- ☐ Completed signed **Application**
- ☐ **Statement of Need**. On a separate piece of paper, please provide a substantial statement of hardship indicating the applicant's need for this requested grant. Please also include information in this statement to clarify anything about the supporting documentation that may be unclear.
- ☐ **Letter of Support**. A Letter of Support from a professional who can confirm the family member's diagnosis as well as offer their perspective on the current situation. The letter is meant to strengthen the request for assistance by giving more information from the professional's experience with the applicant, as well as to vouch for them as a good candidate for our grant assistance. The letter should **not** just state the diagnosis. Examples of professionals who might provide this letter are a doctor, nurse or social worker involved with patient care; a staff member from a national or local non-profit patient organization; a staff member from a homecare company or other pharmacy provider.
- ☐ **Tax Return and W2s**. ALL adults in the household, not just the applicant, must provide a copy of their most recent tax return in its entirety, not just the first two pages, with all corresponding W2s.
    - If self-employed or a business owner, Schedule C must be included with tax returns.
      …..OR…..
    - If applicant does not file taxes, they must provide a signed letter stating why taxes are not filed.
- ☐ **Expenses**. Documentation to verify five (5) of the self-reported **recurring monthly** expense items listed in the application. Even if the applicant is not requesting assistance for (5) different expenses, we require documentation for a minimum of (5). **These bills, invoices, or statements must be presented in their entirety and be the most recent available. They cannot be screen shots of your account, but MUST be actual bills.**

Documentation for **ALL** sources of **income for ALL individuals** in the household, including but not limited to:

- ☐ Most recent pay stub(s) or earning statement(s) to demonstrate one month's earnings
- ☐ Social Security or Disability benefits determination letter
- ☐ Most recent documentation of monthly food stamps or other public assistance
- ☐ Most recent documentation of child support or alimony
- ☐ Most recent unemployment benefit statement(s)
- ☐ Most recent bank statement(s) if necessary to demonstrate sources of income
- ☐ Most recent investment portfolio or retirement account statement(s)
- ☐ Documentation of any and all other sources of income

You can mail, fax or email your completed application. **Always call or email to confirm that the application is received after submitting it.**

P.O. Box 811, Enfield, CT 06083 Tel 800-966-2431 Fax 888-345-0259 admin@colkeen.org www.colkeen.org

Application materials are reviewed in the order they are received on a rolling basis. There is no definitive timeline for the review process. We understand the urgent nature of most needs and applicants are notified of the Board of Directors' decision regarding their application as soon as possible. The applicant, or an authorized contact of the applicant, may check the status of an application at any time by calling or emailing CKF.

INDIVIDUAL ASSISTANCE GRANT APPLICATION

Our Individual Assistance Grant Program, provides assistance and support to individuals and families who are United States citizens or legally living permanently in the United States and who are affected by chronic inherited bleeding disorders.

Grant recipients must wait a minimum of 12 months from the date of approval before applying again. Since our grants are meant to help individuals and families through temporary hardship, second requests undergo more rigorous scrutiny and should show that something is substantially different from the first request. Please contact the Foundation **prior to completing this application if you are a repeat applicant.**

IF THE FAMILY MEMBER WITH A CHRONIC INHERITED BLEEDING DISORDER IS UNDER 18 YEARS OLD, THE APPLICANT WOULD BE THEIR PARENT OR LEGAL GUARDIAN.

First Name: _____Middle Initial: _____ Last Name: _____

Applicant Date of Birth: ___/___/___ What sex was originally listed on your birth certificate: ____ Female

____ Male

Address: _____

City/Town: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

What is the best way to reach the applicant? _____

How did you hear about the Colburn-Keenan Foundation? *(required)* _____

List ALL other individuals living in the same household as the applicant:

Name	Date of Birth	Relationship to Applicant

(If needed, use additional paper to list all individuals in the household)

Name of individual with chronic inherited bleeding disorder: _____

Relationship to applicant: _____ Year of diagnosis: _____

Diagnosis: _____

Additional information for bleeding disorders *(optional):* Severity_____

Does the individual have? (Y/N): Hepatitis _____ HIV/AIDS_____ Current Inhibitor _____

(If needed, use additional paper to list other family members with a chronic illness)

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AUTHORIZED CONTACTS: *(social worker or case manager required; family/friend/others optional)*

Name	Relationship	Phone and/or Email

(If needed, use additional paper to list other authorized contacts for information pertinent to this application)

REQUEST:

Type of Expense	Date Payment Due	Amount Requested
		$
		$
		$
		$
		$
		$

(If needed, use additional paper to list requested amounts)

Total Request:	**$**

Provide a copy of the most recent bill, invoice or statement for each expense for which you are requesting assistance. The amount due shown must match your request. If the applicant is requesting assistance for one or more regular monthly expenses listed below, then copies of these bills/statements will also count toward the requirement of five current bills that need to be submitted.

When requesting assistance for rent, you must have your landlord supply a letter directly to us that includes the following: Tenant's name and address, Landlord's name and address, Monthly rent amount, Total amount due with breakdown (i.e. $1,000 for January, $1,000 for February, $50 in late fees = $2,050).

ASSISTANCE HISTORY: *(If needed, use additional paper to list additional sources of financial assistance)*

Has the applicant applied for a CKF Individual Assistance Grant in the past? _____Yes _____No

Was the request approved? _____ If yes, month/year received:_____ Amount: $_____

Is the applicant currently receiving financial assistance from another organization? _____Yes _____No

If yes, name of organization: _____ Amount: $ _____

Purpose of financial assistance: _____Date assistance started: _____

Has the applicant received financial assistance from another organization in the past year? _____Yes ____No
If yes, name of organization: _____ Amount: $ _____
Purpose of financial assistance: _____Date assistance started: _____

INCOME INFORMATION: Check off **ALL** sources of income for **ALL** individuals in the household and then list the amount received from each source of income:

____Employment ____Self-employment ____Unemployment Benefits

____Social Security/Disability Benefits ____Child Support ____Alimony

____Investments ____Retirement/pensions

____Other:_____

Source of Income	Net amount received monthly	Net amount received annually
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

(If needed, use additional paper if needed to list all sources of income in the household)

Totals:	$	$

Do you receive food stamps?

If yes, how much do you receive a month?_____

Do you receive public assistance?

Housing - If yes, how much do you receive a month?_____

Health Insurance – If yes, who in the household is covered by this insurance? Please list names:

_____

Other

a. What do you receive?_____

b. How much do you receive a month?_____

EXPENSE INFORMATION: List **ALL** sources of expenses for the household and the amount of each expense.

Source of Expense (may include, but not limited to)	**Monthly Amount**	**Annual Amount**
Mortgage/rent	**$**	**$**
Homeowner's Insurance	**$**	**$**
Property Taxes (if not escrowed in mortgage)	**$**	**$**
Utilities (electric, heat, etc.)	**$**	**$**
Cable and/or internet	**$**	**$**
Home Phone	**$**	**$**
Cell Phone	**$**	**$**
Medical Insurance (if not a deduction out of paycheck)	**$**	**$**
Auto Loan #1	**$**	**$**
Auto Loan #2	**$**	**$**
Auto Insurance	**$**	**$**
Gas for Auto	**$**	**$**
Public transportation Expenses	**$**	**$**
Education Expenses	**$**	**$**
Childcare Expenses	**$**	**$**
Groceries/Food	**$**	**$**
Addt'l Expense:	**$**	**$**
Addt'l Expense:	**$**	**$**
Addt'l Expense:	**$**	**$**

(If needed, use additional paper to list all regular expenses in the household)

Totals:	**$**	**$**

- ALL regular expenses, monthly and/or annual, must be included in the above list.

IF YOU HAVE CREDIT CARDS, PLEASE COMPLETE THE BELOW CHART:

Card Name	**Minimum Monthly Payment**	**Total Amount Due**	**What Was Purchased**
(If needed, use additional paper to list all credit cards in the household)			
Totals:	**$**	**$**	

INDIVIDUAL GRANT AGREEMENT AND CONSENT FORM:

I confirm that the information provided on this application form and in all supporting documentation is complete and accurate. I understand that grant assistance is not guaranteed and I should always have contingency plans to cover necessary expenses in case my grant request is not approved. I agree to provide all requested documentation in a timely fashion. I understand that, if my grant request is approved, payments will be sent directly to the company to which they are due, except in cases of documented reimbursement. I understand that payments cannot be disbursed until I submit this documentation and it is my responsibility to ensure that my accounts do not default due to the grant payment not being able to be sent out ahead of the due date. The Colburn-Keenan Foundation, Inc. is not responsible for any cancellation of service or coverage. If approved, I commit to notify and provide documentation of any changes in my income or financial situation that may impact upcoming approved grant payments. Failure to provide any such updates could jeopardize further grant funds. If I am approved, I agree to promptly return to the Colburn-Keenan Foundation, Inc. any refund check from a company due to overpayment resulting from grant funds.

I give consent, and hereby authorize, the Colburn-Keenan Foundation, Inc. to verify the information contained in this application and in all supporting documentation. The Colburn-Keenan Foundation, Inc. may contact any company, agency, medical office, records bureau, insurance carrier, referral source, case manager, treatment center, doctor, nurse, or service provider to obtain any further necessary information in the course of grant review and, if approved, grant disbursement. The Colburn-Keenan Foundation, Inc. is permitted to phone, fax, write, or email with any company from which I submit a bill, invoice, or statement as part of this grant application. All records, including records in these subject areas financial, medical history and treatment, vocational records, case management, treatment plans (including hospice advance directives) may be shared with, released to, provided to, etc. the Colburn-Keenan Foundation, Inc. This information has been disclosed to the Colburn-Keenan Foundation, Inc. from records which may be protected by state and/or federal laws that protect confidentiality. These laws prohibit the Colburn-Keenan Foundation, Inc. from making further disclosure of this information without the specific written consent from the applicant, or as otherwise permitted by state law. Any and all information pertaining to grant applicants, grant applicant's medical records, medical information, financial information, etc. is strictly confidential and proprietary to the Foundation consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I release any of the involved companies, agencies, institutions, persons, etc. and the Colburn-Keenan Foundation, Inc. staff and counsel from all legal responsibility or liability that may arise from authorized release of this information. I understand that I may revoke this consent at any time. This consent automatically expires one year after the date signed.

By signing, I attest that I have read the above and agree to abide by the policies of the Individual Grant program as outlined in this application and through all other correspondence with the Colburn-Keenan Foundation, Inc. I attest that I am a United States citizen or legally living permanently in the United States.

Signature: _____ Date: _____

Print Name: _____

Pursuant to section 4945(g) of the Internal Revenue Code and section 53.4945-4 of Treasury Regulations, the above is information needed by the Colburn-Keenan Foundation in the awarding of grants to individuals.