Charitable Foundation Program
Application for Assistance

Complete the form below and return the application along with the required supporting documentation to the **Joseph Thomas Foundation, 928 Sylvia St., Weatherford, TX 76086.**

To be eligible for consideration for assistance, applicants must have custody of a medically fragile child with a mental or physical impairment that substantially limits one or more major life activities, who is between the ages of zero and eighteen years old, resides within our current coverage area and can provide proof of denial of coverage for the item or service being requested from insurance and Medicaid. The impairment may be congenital or acquired by accident, injury or disease.

Applications are approved by the Foundation's Board of Trustees. Applications may be mailed or emailed. All applications must be signed and dated. Funds will not be awarded to cover the cost of goods purchased or services performed prior to the application. Applications that do not meet criteria or that have not provided the required support documentation will be denied.

All applicants will receive notice of approval or denial of the application in writing. Foundation staff is available to answer questions and may be contacted by phone: 325-725-1380 or by email: john@josephthomasfoundation.org.

Date: _____

Applicant Information

Name of Child and Date of Birth: _____
Name of Applicant: _____
Street Address: _____
City and Zip code: _____
Phone: _____
Email: _____

Referral Information

Name of Representative: _____
Organization: _____
Street Address: _____
City and Zip code: _____
Phone: _____
Email: _____

_____ _____
Applicant Signature Date

_____ _____
Agency Representative Date

Type of Disability

___ Mental Retardation or Developmental Disability
___ Brain Injury
___ Orthopedic
___ Other (please specify):

Living Situation of Applicant

___ Lives with family (biological, relatives or adoptive)
___ Lives with foster family
___ Lives in supported living setting (less than 24 hour staff supervision)
___ Lives in supervised living setting (24 hour staff supervision)
Type of living setting (check one)
___ Staffed Apartment
___ Group Home
___ State-operated Facility (specify): _____
___ Nursing Home
___ Other (specify):

Applicant Receives the Following Public Benefits (please check all that apply)

___ SSI $_____ per month (combined)
___ SSDI $_____ per month (combined)
___ Food Stamps Medicaid
___ Medicare
___ Other Benefits (specify): _____
___ Applicant receives no public benefits or assistance

Gross Annual Income of the Family $_____
Number of persons in the family unit _____

Type of Assistance Requested (please check one)

___ Medical or Dental Care and Equipment
___ Rehabilitation Training, Services or Devices
___ Supplemental Education Assistance
___ Personal Goods and Services
___ Transportation Assistance
___ Other (specify):

Briefly describe the applicant's condition and situation.

Describe the specific item, equipment or support that is being requested.

Briefly summarize why the item, equipment or support requested will benefit the recipient.

Amount Requested

NOTE: An estimate or invoice from two or more vendors (when possible) or other documentation of the cost of the item(s) requested must be enclosed. If the request is for dental care, a treatment plan must be enclosed with the application. All incomplete applications will be denied.

$_____

Has an effort been made to secure funding for the requested item, equipment or support through other sources?

___ Yes
___ No

If yes, which agency or resource was the request made (please check all that apply)

___ Insurance
___ Medicaid
___ Medicare
___ Other (specify): _____

IF THE ANSWER IS YES, PROOF OF DENIAL OR PARTIAL APPROVAL MUST BE INCLUDED AS SUPPORTING DOCUMENTATION TO THE APPLICATION.

Further Requirements

A letter of recommendation from a Physician must accompany this application. The letter must be signed with the Physician's address, phone number and email included.

Authorization

I certify the information I have stated and all supporting documentation is true and correct and that all of the household income is reported. Deliberate misrepresentation of information may subject me to denial of assistance or services. If assistance or service is provided and later determined that I misrepresented information, I may be required to reimburse the Foundation the funds. I understand all information will remain as private as possible within these entities. I do give the Foundation permission to contact the Physician in regards to this request.

I have read, understand and agree to the policies and requirements as stated above.

_____ _____

Signature Date