

**The Cindy Donald Dreams of Recovery Foundation, Inc.**  
**Application Form**

Please complete all pages and questions on the application

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

\*\* Please attach a photocopy of your Birth Certificate or US Passport \*\*

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Person Completing Application (if different from Applicant) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

How did you hear about The Cindy Donald Dreams of Recovery Foundation?

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

Nature of Injury (Check all that apply):

\_\_\_\_ Brain Injury

\_\_\_\_ Spinal Cord Injury

Level of Injury? \_\_\_\_\_

ASIA Classification? \_\_\_\_\_

Date of Injury \_\_\_\_\_ Please describe how your injury occurred:

\_\_\_\_\_

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The Cindy Donald Dreams of Recovery Foundation is intended to be the funding source of last resort. Other funding sources are often available for requests such as computers, assistive technology, adaptive equipment, etc. Accessing these funding sources will maximize the dollars available to you. Please document below, other funding sources you have applied to for assistance and the status of assistance provided:

Awaiting Eligibility	Eligible & Enrolled	Have applied but not eligible	Not Applicable
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**Personal Support Services**

Community Care Services (CCSP)  
Independent Care Waiver Program (ICWP)  
SOURCE Waiver

**Financial Resources**

Medicaid  
Medicare  
SSI  
SSDI  
Private Insurance  
Short Term Disability  
Long Term Disability  
Vocational Rehabilitation (VR)  
PASS Plan  
Indigent Care Trust Fund  
Veteran's Administration

**Other Funding sources**

Centers for Independent Living  
Victims Compensation Fund  
Friends of Disabled Adults & Children  
Assistance Technology Resource Centers

What is your current monthly income from all sources? \_\_\_\_\_

Are you currently living in a nursing facility, group home, personal care home, or other facility?

Yes No

If yes, please describe \_\_\_\_\_

If living in your own home, who do you live with? \_\_\_\_\_

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Do you require personal assistance services? Yes No

If yes, how many hours per day and who provides these services?

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Do you have transportation available when you need it? Yes No

What source and who pays for it? \_\_\_\_\_

\_\_\_\_\_  
Please describe briefly how the funds you are requesting will be used. What goods or services will be purchased; how will they benefit you; how will they improve your independence? What is the total amount of funding you are requesting (cannot exceed \$x,xxx)? \_\_\_\_\_

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

How will financial assistance allow you to be more a part of your community?

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

If the service or good you are requesting cost more than \$xxxxx, how will you pay for the remaining costs if you are approved for financial assistance?

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

Are there other factors you may wish to be taken into consideration (health factors, living arrangement, financial or family issues)?

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

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In order to be considered, please provide an estimated cost of the equipment or therapy you are requesting. That agency, vendor, or individual provider will provide the requested services or good if funds are approved.

1. Service or Good  
Provided:

Address:

Phone:

Contact Person

2. Service or Good  
Provided:

Address:

Phone:

Contact Person

3. Service or Good  
Provided:

Address:

Phone:

Contact Person

4. Service or Good  
Provided:

Address:

Phone:

Contact Person

- A. By signing below, I certify that:  
I have read and understand the Criteria and Guidelines set by TCDDORF Committee  
I have provided truthful, complete and accurate information on this applicant,  
and  
I have exhausted all other insurance and governmental funding sources before applying to TCDDORF Committee
- B. I represent and assure the Committee that, if I am granted an award, I will:  
Use the funds for the purpose state in this application; and  
Promptly report in writing the TCDDORF any change in the availability of Insurance and Governmental Funding sources that may affect my eligibility for funds.
- C. I understand and acknowledge that:  
TCDDORF has the right to rely on the information contained in this Application or any subsequent amendments; and  
TCDDORF has the right to withdraw or modify any disbursement in the event that:  
The information contained in this application or any subsequent amendment should at any time be determined to be false, incomplete, inaccurate, or misleading, or  
  
The funds are used for a purpose other than stated in this application; or  
  
TCDDORF becomes aware of any change in my status or circumstance that may affect my eligibility, and  
  
It is my responsibility to determine if the receipt of funds legally impacts other benefits that I may receive.

I certify that, to the best of my knowledge and ability, the information included in the application is accurate as of the date signed below. I also acknowledge that I am aware that if I receive The Cindy Donald Dreams of Recovery Foundation award my name or any images may be used by The Cindy Donald Dreams of Recovery Foundation for media and / or promotional purposes.

Signature \_\_\_\_\_

Date \_\_\_\_\_

(For applications submitted by email, this signature page must, in addition, be submitted by hard copy)

## Authorization Form

**By signing below**, I hereby authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to The Cindy Donald Dreams of Recovery Foundation or its designee and its legal representatives.

Any physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company, Third Party Administrator, the Medical Information Bureau or any similar organization, institution or person, any employer, group plan holder, or certificate holder.

If the record released contains information relating to HIV test results, AIDS, alcohol abuse or mental health care, enough of this information is to be released to accomplish the purposes for which the information is requested and to the extent permitted by law.

I understand that the information released to The Cindy Donald Dreams of Recovery Foundation may be used to process my application for disbursement from the Fund and may be given to any person or entity carrying out a function for, on behalf of, or in conjunction with TCDDORF.

This information may also be re-disclosed as otherwise specifically required or permitted by law. This authorization shall remain in effect until revoked by me in writing

Signature \_\_\_\_\_ Date \_\_\_\_\_

For applications submitted by email, this Release/Authorization must, in addition, be submitted by hard copy.