



POSSIBILITIES GRANT APPLICATION

Quarterly Funding Cycles

Applications Due By: February 1st - May 1st - August 1st - November 1st

Incomplete applications will not be considered.

Questions? Please call: 1.800.895.4728

GRANT APPLICATION CHECKLIST

Make certain to complete the grant application in its entirety. Every section must be completed. Applications that are incomplete or missing required supporting documents will **NOT** be accepted. Before submitting the application, use the following checklist:

Background Information (Pg. 4)

- Provide a good description and detail of your medical condition or disability.
- Be specific. Your answer helps the review committee understand the need for assistive technology.

Grant Request (Pg. 5)

- **NOTE:** Possibilities Grant dollars cannot be used to pay for devices or services purchased prior to approval of your application.
- Be as specific as possible on the device(s) and/or services being requested.
- Information must include the vendor name and/or where the assistive technology can be purchased.
- A dollar amount requested or cost of the device must be included.
- Provide/attach any other supporting documentation (assessments, evaluations, etc.) from consultants or specialists recommending this device if available.

Funding History (Pg. 6)

- It is important that all potential forms of funding for AT have been investigated and explored before applying. Review your private health, Medicare and Medicaid insurance policies to determine what assistive technology or durable medical equipment coverage is provided.
- Provide copy of denial letters (if applicable) from insurance/health coverage.

Eligibility Criteria (Pg. 7)

- Attach a copy of the most recent federal tax return form: 1040, 1040A or 1040EZ.
- If you are not required to file for the past year, you **must provide** a copy of Social Security Benefits letter or annual income.

Signature (Pg. 8)

- Required signature of application to verify that all application information provided is true and complete and also gives consent to use publicity material about your award.
- Without dated signature, the application will not be considered complete and eligible for review.

Please Note:

The Possibilities Grant is a last resort funding program, meaning all other funding sources must be used before an applicant will be considered. It also means if a certain entity is required to pay for AT, this program will not cover it. For example, AT required by law to be purchased by a school will not be funded by this grant. In addition, augmentative and alternative communication (AAC) devices will not be funded as well as they are paid for by most insurances; this includes tablets with AAC apps for communication purposes.

Note also that because of this program's limited funds, hearing aids will not be considered. We will however consider alternative hearing devices such as the Pocket Talker or Comfort Duett. For more information, please contact our office at 1.800.895.4728 and ask to speak to one of our consultants.

While there is no cap set on the amount that may be requested, but it is expected awards will not exceed \$2,000. As public or private funds may only cover a portion of assistive technology costs, Possibilities Grant funds can be used in partnership to close that gap.

GRANT APPLICATION FORM

Incomplete applications will not be considered.

Questions? Please call: 1.800.895.4728

CONTACT INFORMATION

Applicant

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

County: _____ Date of Birth: _____

Phone: Home _____ Work _____

E-mail address: _____

Living Arrangement (Own home, nursing facility, other-specify): _____

Note: Please include the following if completing the application for the person above.

Name: _____

Title/Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Phone: Home _____ Work _____

E-mail address: _____

BACKGROUND INFORMATION

Describe your disability to include diagnosis, severity, prognosis, and functional limitations. Try to paint a picture of yourself to help us understand what your disability is, how long you have had it, if it is temporary or permanent, and how it impacts your day-to-day activities. (Please be specific.)

Are you currently working with ND Assistive staff?

No _____ Yes (Name) _____

Is there a Healthcare Professional who could verify your disability?

(i.e. licensed physician, audiologist, teacher, speech language pathologist, physical therapist, occupational therapist, home health, etc.)

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Name: _____ Title: _____

Phone: _____ E-Mail: _____

EQUIPMENT AND/OR TRAINING REQUESTED

Include/attach vendor information, a product description, and estimated cost. (Please be specific.)

NOTE: Possibilities Grant dollars cannot be used to pay for devices or services purchased prior to approval of your application.

Device	Vendor Information	Estimated Cost

Do you think you will need training to successfully use the device(s) requested?

Yes _____ No _____

Where do you plan on using this device(s) (i.e. school, home, work, etc.)?

How did you determine what assistive technology was appropriate for your needs? _____

Did you have a formal evaluation? Yes _____ No _____

If yes, please list who with. _____

Did you try out the requested assistive technology for a period of time or participate in a product demonstration? Yes _____ No _____

If yes, please explain. _____

NOTE: If you have not had a formal evaluation or a product demonstration, please contact us at 1.800.895.4728 to schedule one. Priority will be given to those who have worked with one of our ND Assistive Technology Consultants.

Explain why this device increases your independence on a day-to-day basis.
(Please be specific.)

FUNDING HISTORY

NOTE: As a reminder, this is a last resort funding program (see Grant Application Checklist for further explanation).

Have you received a Possibilities Grant in the past? Yes _____ No _____

Have you approached any other funding sources before seeking help from this program? (i.e. Workforce Safety and Insurance, a Medicaid Waiver, the Public School System, Vocational Rehabilitation, the Great American Bike Race, North Dakota Association for the Disabled, etc.) Yes _____ No _____

Please explain:

What Medical insurance do you currently have? (i.e. private insurance, Medicare, Medicaid, Medicaid Waivers, Workers Compensation, Veterans Administration, etc.)

Is the assistive technology you are requesting funding for covered by your insurance? Yes _____ No _____

If "No", please send a copy of your denial letter.

Assistive technology funding can sometimes be confusing. If you are unsure if your request is appropriate for the Possibilities Grant, please call us at 1.800.895.4728. We are happy to help you explore and understand your assistive technology funding options.

Describe any financial circumstances that make the purchase of the requested assistive technology difficult. Although information about assets is not requested, those monthly or routine expenses related to disability that create financial hardship should be mentioned.

Required Documentation

Attach your most recent federal tax return form: 1040, 1040A, or 1040EZ – no supporting Forms or Schedules are necessary. **If you do not file taxes, a copy of Social Security Benefits Letter or your annual income is required.**

Your application is not complete without this information.

****Your return will be compared to the table below for eligibility****

Applicant Income Guidelines for January 1, 2019 to December 31, 2019	
<u># of Persons in Household*</u>	<u>gross income</u>
1	\$37,470
2	\$50,730
3	\$63,990
4	\$77,250
5	\$90,510
6	\$103,770

Responsibilities and Consent Signature(s)

I agree to provide ND Assistive with my story and pictures of myself using the device(s) purchased with Possibilities Grant award funds. **INITIALS:** _____

My signature below gives ND Assistive permission to use my name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, stories, and the like, taken or made on behalf of my involvement with ND Assistive activities. **INITIALS:** _____

The information I have provided on this application is true and complete to the best of my knowledge. If under 18 years old or under guardianship, **both** applicant and parent/guardian must sign. **INITIALS:** _____

I understand incomplete applications will not be considered. **INITIALS:** _____

(Applicant Signature)

(Date)

(Parent/Guardian Signature, if applicable)

(Date)

Your completed application may be sent to one of the following:

Mail:
ND Assistive
Possibilities Grant
3240 15th Street South, Suite B
Fargo, ND 58104

Fax:
701.365.6242

Email:
pposey@ndassistive.org

Questions? Please call: 1.800.895.4728