



## POSSIBILITIES GRANT APPLICATION

Applications will be reviewed weekly.

**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. 7)**

- 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. 9)**

- **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. 12)**

- 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. 14)**

- 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. 16)**

- 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.

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.

All Durable Medical Equipment including lift chairs require an OT or PT assessment which includes measurements for the requested device. Due to the program's limited funds, only a set number of lift chairs will be approved each year.

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.

To be eligible, your total family/household income must fall under the guidelines listed in the table below:

Applicant Income Guidelines for January 1, 2023 to December 31, 2023	
# of Persons in Household*	Gross income
1	\$58,320
2	\$78,880
3	\$99,440
4	\$120,000
5	\$140,560
6	\$161,120

# 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.]

**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.

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

**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.)?**

[Where do you plan on using this device(s)]

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

[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.

[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.

[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.)**

[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:**

[Please explain]

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

[What Medical insurance do you currently have?]

**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.

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## 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, 2023 to December 31, 2023	
<u># of Persons in Household*</u>	<u>estimated median income</u>
1	\$58,320
2	\$78,880
3	\$99,440
4	\$120,000
5	\$140,560
6	\$161,120

**Do you file Federal income taxes? Yes\_\_\_\_\_ No\_\_\_\_\_**

If **YES**, you must provide a copy of last year's Federal IRS 1040 tax form(s) filed by you and members of your family/household.

If **NO**, to confirm your income eligibility, please mail or fax documentation that proves one of the following:

Evidence of your total family/household income, such as recent Social Security Administration retirement benefit statement(s) or other pension benefit statement(s).

For the purpose of determining eligibility for the Possibilities Grant program, ND Assistive defines “income” and “household” as follows:

“Income” is all income actually received by all members of a household. This includes salary before deductions for taxes, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, lottery winnings, and the like. The only exceptions are student financial aid, military housing and cost-of-living allowances, irregular income from occasional small jobs such as baby-sitting or lawn mowing, and the like.

A “household” is any individual or group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An “economic unit” consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him/her, both people shall be considered part of the same household. Children under the age of eighteen living with their parents or guardians are considered to be part of the same household as their parents or guardians.

## 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:** \_\_\_\_\_

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**(Applicant Signature)**

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**(Date)**

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**(Parent/Guardian Signature, if applicable) (Date)**



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

**Mail:  
ND Assistive  
Possibilities Grant  
3240 15<sup>th</sup> Street South, Suite B  
Fargo, ND 58104**

**Fax:  
701.365.6242**

**Email:  
[pposey@ndassistive.org](mailto:pposey@ndassistive.org)**

**Questions? Please call: 1.800.895.4728**