Application#: _____ Voucher#: _____

Date Received: _____ For Office Use Only Check#/CC: _____

Blanche Fischer Foundation

4931 SW 76th Ave #346 <> Portland, Oregon 97225
Phone: 503-246-4941; Fax: 971-865-2142 <> Website: www.bff.org

The Blanche Fischer Foundation is a private, nonprofit charitable organization founded in 1981 to assist Oregon residents who have a **permanent** physical disability and who demonstrate a financial need. (The Foundation uses the Federal Poverty Level Chart for guidance.)

Applicants may apply for financial aid for assistive devices, special equipment or for such other purposes as the foundation finds appropriate.

Ineligible expenses:

- Housing expenses (rent, mortgage)
- Daily living expenses (food, utilities)
- Entertainment expenses
- Gym memberships
- Education
- Payments on loans or credit cards
- Payments on previously purchased items
- Startup expenses for a business
- Training for service dogs
- Modifications to non-owner-occupied homes

Please Read Carefully

- Both the Application and Income Worksheet must be filled out completely and signed by the applicant or applicant's legal guardian. No other forms will be accepted in place of the signed income worksheet.

- Medical or other satisfactory verification of disability (letter from physician, social worker, case worker, etc.) is required. The letter must state that the applicant has a physical disability. Listing "medical condition or health impairment" is not sufficient. **An SSDI Notice is not accepted as verification**. Mental health disabilities are not eligible for a grant. To maintain your privacy, please do not include information about your mental health.

- In requests for a portable air conditioner or medical device, a statement signed by a healthcare provider must accompany the application verifying the device is a medical necessity.

- For the purposes of the application, accepted healthcare providers are: Physicians, Nurses, Nurse Practitioners, Physician Assistants, Naturopathic Physicians, Physical Therapists and Medical Social Workers with access to an applicant's health record.

- We do not accept faxed applications. You must MAIL the original, **along with the required documentation**, to the Foundation. This is necessary for the Foundation to comply with state and federal requirements.

- Payment is made to vendors. Direct cash assistance is not provided.

- If the request involves an automobile, a driver's license, proof of ownership and proof of insurance must be provided before payment will be issued to vendor. This is not needed at submission of application.

- The Foundation does not maintain an emergency fund, nor does it provide emergency assistance.

- Applicant eligibility is based on a 3-year cycle. The cycle starts upon the awarding of the first grant. An individual is eligible for up to $1,200 in any 3-year period. The individual may make multiple applications or a single application in a 3-year period. The awarding of a single $1,200 grant is dependent on the availability of funds. The accumulative amount may not exceed $1,200.

- Grants are reviewed on a quarterly basis.

- Applications must be received and include all required documentation by the end of the month in January, April, July and October.

- Applicants will be notified of the status of their application and awards will be made in March, June, September and December.

- Applications that are not funded in a quarter will be reconsidered the following quarter. If an application is not funded after being reviewed in four quarters, the application will be withdrawn.

Please Read Before Signing

All grants made assume the accuracy of this application. I understand that any substantial errors, ***including omissions****, may result in cancellation of a grant. I also understand that if a grant is awarded, payment shall be made to the vendor.* ***No payment will be made directly to me or to my personal credit card****.* ***Any refund is the property of the Foundation.*** *I further understand that all decisions as to eligibility are made at the sole discretion of the Blanche Fischer Foundation and that its decisions are final.*

I understand that all grants awarded by the Blanche Fischer Foundation must be reported on the foundation's federal tax return and, as such, grantees' names and addresses are a matter of public record.

Signature(s):

_____ _____

Applicant Signature Print Name

_____ _____

Date Parent/Guardian (circle whichever is appropriate)

Before mailing this application…

1. _____ Are all sections complete?
2. _____ Have you signed and attached the Income Worksheet?
3. _____ Have you attached documentation from a medical or other professional verifying disability?
4. _____ Have you attached a copy of a vendor's price quote?

Mail the completed application and documentation to:

Blanche Fischer Foundation
4931 SW 76th Ave #346
Portland, OR 97225

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GRANT APPLICATION

Applicant (person for whom assistance is being requested - please print):

Name: _____

Address: _____

_____ _____
City/Zip Code County

Telephone/TTY: (____)_____ Email: _____

A. Have you applied for a grant from us before? Yes _____ No _____ What Year? _____

B. Have you applied to another organization to purchase this item? Yes _____ No _____

From whom? _____ How much? $_____

C. Have any been approved? Yes _____ No _____ Under Review _____

By whom? _____ In what amount? $_____

Information About Your Disability

1. Briefly describe your physical disability: _____

_____

_____

_____

2. How long has this condition existed? _____
3. Is your condition permanent? Yes _____ No _____
4. What limitations exist for you because of this disability? _____

_____

_____

_____

5. For what specific piece of equipment or other assistance are you requesting funding?

_____

_____

6. How will this grant improve your functioning or quality of life? _____

_____

_____

_____

_____

7. How much does the requested item cost? $_____

   a. How much are you able to contribute to the cost? _____

   b. Given grant limits, how much do you ask the Foundation to contribute? _____

8. Name and address of vendor or supplier (**attach copy of price quotes or order information**):
   (If we find a source for the requested item at a lower cost, we will use our vendor.

_____

_____

OTHER INFORMATION YOU MAY WISH US TO CONSIDER (attach letter, if desired):

_____

_____

Household Information

Applicant's birth date: _____ Age:_____

If applicant is a minor, name of parent(s) or guardian(s):_____

Number of people in household: _____ # of adults: _____ # of children: _____

Relationships of other adults in household: _____

Number of wage earners in household: _____ Number of SS recipients: _____

Occupation(s)_____

Employer(s) name(s):

_____

INCOME WORKSHEET

*Note: **All** household members and their gross income must be included to aid in calculating the household Federal Poverty Level. All income listed must use pre-tax amounts.*

MONTHLY INCOME	
Social Security Benefit (list Medicare deduction under Expense)	
Social Security Disability Insurance (SSDI)	
Supplemental Security Income (SSI)	
Primary earner Wages (paid employment)	
Secondary earner Wages (paid employment)	
Pensions	
Annuities	
Child Support	
Alimony	
Food Stamps	
Business Income	
In-kind support (housing, etc.)	
Other	
Other	
Other	
A. TOTAL INCOME	
MONTHLY EXPENSES	
Housing	
Rent	
Mortgage	
Property Taxes	
Utilities	
Food	
Transportation	
Auto Insurance	
Car Payment	
Bus Passes	
Health Insurance	
Other Insurance (specify)	
Co-pays	
Pharmaceuticals	
Durable Medical Equipment operational expense	
In-home care	
Other	
Other	
Other	
Other	
B. TOTAL EXPENSE	

I certify that to the best of my knowledge all the information on this form is correct. I also understand that failure to report all requested information completely and accurately may result in denial of my grant application or withdrawal of an award.

_____ _____ _____

Signature Print Name Date