



Blanche Fischer Foundation

- Empowering low income Oregonians with permanent physical disabilities

INDIVIDUAL GRANT APPLICATION — REQUIRED SUBMISSION PACKET

Maximum Award from BFF: \$1,500 (hard cap)

Important: If your total cost is more than \$1,500, you may still apply; however, you **must** explain how the remaining balance will be paid. **BFF will not pay more than \$1,500 and will pay last**—BFF’s payment will be issued to the vendor only after the remaining balance has been paid/secured per your plan.

START HERE: REQUIRED SUBMISSION CHECKLIST (REQUIRED)

Applicant Name: _____

Date Submitted: _____

Required Submission Checklist (ALL required)

Please include **ALL** of the following documents. Incomplete applications will not be considered. Initial next to each item to confirm it is included.

1. Completed Application Form (Sections 1–6) **Initials:** _____
2. Completed & Signed Income & Expenses Worksheet (separate page) **Initials:** _____
3. Quote or Vendor Estimate for the requested item or service **Initials:** _____
4. Advocacy Statement (form in this packet or letter on letterhead) **Initials:** _____
5. Disability Verification Letter (must meet requirements in this packet) **Initials:** _____
6. Copy of Oregon State ID, Driver’s License, or Military ID (proof of residency) **Initials:** _____
7. Demonstration of Engagement & Personal Story Form (in this packet) **Initials:** _____
8. Signed Certification and Agreement Page **Initials:** _____

Submission Instructions (recommended for faster review)

Email subject line: “Individual Grant Application – [Applicant Last Name]”

Preferred: submit as **one PDF** with documents in the order listed above.

APPLICANT INFORMATION

Full Name: _____

Date of Birth: _____ Age: _____

Address of Residence: _____

City: _____ State: _____ ZIP: _____

County: _____

Mailing Address (if different): _____

Phone: _____ Email: _____

Best way to reach you: Email Text Phone

If applicant is a minor:

Parent/Guardian Name(s): _____

HOUSEHOLD INFORMATION

Total People in Household: _____

Adults: _____ Children: _____

Other Adults' Names and Relationship to Applicant: _____

Number of Wage Earners: _____

Number Receiving Social Security: _____

Occupations / Sources of income in household:

GRANT REQUEST SUMMARY

A) Disability Summary (Applicant-Completed)

Brief description of disability/condition (1–2 sentences):

How long have you had this condition? _____

Is your condition permanent? Yes No Unsure

Name of medical provider verifying disability (for required verification letter):

Provider credentials: MD NP PA

Important: Your application must include a Disability Verification Letter that meets the requirements included in this packet. Applications without a compliant letter will not be reviewed.



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B) Requested Item or Service

What item or service are you requesting funding for?

Vendor name (from quote/estimate): _____

Total cost of item/service (from vendor quote/estimate): \$_____

Applicant contribution (confirmed): \$_____

Amount requested from BFF (MAXIMUM \$1,500): \$_____

If total cost exceeds \$1,500, explain how the remaining balance will be paid (REQUIRED):

Eligibility rule: BFF grant cap is \$1,500.

Payment sequencing (BFF pays last): If the total cost exceeds \$1,500, you must explain how the remaining balance will be paid. BFF's payment will be issued to the vendor after the remaining balance has been paid/secured per your plan.

C) Impact and Other Sources

How will this grant help your quality of life or independence? (2–4 sentences):

Have you tried to get help from other sources? Yes No

If yes, please explain:

INCOME & EXPENSES WORKSHEET (REQUIRED)

Applicant Name: _____

Month/Year (or "Current"): _____

Primary Earner Name: _____

Secondary Earner Name (if any): _____

Monthly Income

Enter monthly amounts. If a category does not apply, write 0.

Monthly Income Categories	Primary Earner	Secondary Earner	Total
Social Security Benefits (<i>List Medicare deductions under Expenses</i>)	\$	\$	\$
Social Security Disability Insurance (SSDI)	\$	\$	\$
Supplemental Security Income (SSI)	\$	\$	\$
Gross Wages (Employment)	\$	\$	\$
Pensions	\$	\$	\$
Annuities	\$	\$	\$
Child Support	\$	\$	\$
Alimony	\$	\$	\$
Food Assistance (SNAP)	\$	\$	\$
Business Income	\$	\$	\$
Other Income (Specify): _____	\$	\$	\$
TOTAL MONTHLY INCOME			\$



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Monthly Expenses

Enter monthly amounts. If a category does not apply, write **0**.

Monthly Expenses Categories	Monthly Amount
Housing – Rent/Mortgage	\$
Housing – Property Taxes	\$
Housing – Utilities	\$
Food/Groceries	\$
Transportation – Auto Insurance	\$
Transportation – Car Payment	\$
Transportation – Public Transportation (Bus Passes)	\$
Insurance – Health Insurance	\$
Insurance – Other Insurance (Specify): _____	\$
Medical – Co-pays	\$
Medical – Pharmaceuticals	\$
Medical – Durable Medical Equipment (Operational Costs)	\$
Medical – In-home Care	\$
Other Expenses (Specify): _____	\$
TOTAL MONTHLY EXPENSES	\$

Certification - I certify, to the best of my knowledge, that all the information on this form is correct. I understand that failure to report all requested information completely and accurately may result in denial of my grant application or withdrawal of an award. (Guardians sign on behalf of dependents.)

Signature: _____ **Print Name:** _____

Date: _____

CERTIFICATION AND AGREEMENT (REQUIRED)

By signing below, I confirm:

1. I have read and understand the grant process and eligibility requirements.
2. The information provided is accurate to the best of my knowledge.
3. I understand incomplete applications will not be reviewed.
4. Payments will be made directly to vendors (not to applicants).
5. Grant decisions are final and made at the sole discretion of the Foundation.
6. My name and address may appear in public tax filings.
7. I understand the maximum award from BFF is \$1,500, and BFF will not pay more than \$1,500.
8. If the total cost exceeds \$1,500, I understand I must provide a clear plan for how the remaining balance will be paid, and that BFF pays last—BFF's payment will be issued to the vendor only after the remaining balance has been paid/secured according to my plan.
9. I understand a compliant Disability Verification Letter is required, and applications missing it (or not meeting requirements) will not be reviewed.
10. I agree that BFF can share my story to inspire others with permanent physical disabilities.

Applicant Signature: _____

Printed Name: _____

Date: _____

If someone else helped complete this form:

Preparer Name: _____

Relationship to Applicant: _____



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ADVOCACY STATEMENT FORM

The Blanche Fischer Foundation (BFF) requires an advocacy statement from a person who is familiar with the applicant's situation and can attest to the need for funding. This statement helps confirm the relevance and urgency of the request and ensures that the application is clear, realistic, and complete.

An advocate may be:

- A professional (e.g., caseworker, rehabilitation counselor, independent living specialist, healthcare worker)
- A family member or trusted support person with in-depth knowledge of the applicant's situation

Advocate Information

Name of Advocate: _____

Relationship to Applicant: _____

Organization Name (if applicable): _____

Phone: _____ **Email:** _____

Length of Time You've Known the Applicant: _____

Advocacy Statement

In your own words, briefly explain why this request is important and how it will improve the applicant's independence or quality of life.

If the total cost exceeds \$1,500, please describe how the remaining balance will be paid and confirm that BFF will pay last (after the remaining balance is paid/secured).**

I have reviewed the application and confirm that it is accurate and complete to the best of my knowledge.

Signature of Advocate: _____

Date: _____

This form must be submitted with the applicant's completed grant application.

DEMONSTRATION OF ENGAGEMENT & PERSONAL STORY FORM

The Blanche Fischer Foundation (BFF) requires applicants to share how they are actively working to improve their independence, quality of life, and connection to others. This information helps us better understand your goals, resilience, and resourcefulness.

This must be submitted with your completed grant application packet.

Section 1: Your Personal Story

Tell us about yourself in your own words:

- What would you like us to know about your experience living with a physical disability?
- What motivates you?
- What personal or community goals are you working toward?

You may:

- Write a short narrative (1–2 paragraphs)
- Share a poem, quote, or something meaningful to you
- Include a photo or artwork (optional)

Applicant response:

Section 2: Demonstration of Engagement

Please answer the following:

1. Describe any programs or services you're actively participating in (e.g., physical therapy, independent living classes, vocational training) _____
2. Are you working or volunteering in any capacity? (e.g., part-time work, remote jobs, helping in your community) _____
3. Are you pursuing education or certifications? (e.g., GED, college, online courses, life skills classes) _____
4. Are you involved with any groups, clubs, or peer support? (e.g., support groups, advocacy networks, recreation programs) _____
5. Do you follow any routines or health plans that help you manage your condition? _____

You may include any of the following if you wish:

- Letters of reference or support
- Program enrollment confirmations
- Photos of activities or accomplishments
- Journal entries or creative expressions

Applicant Signature: _____ **Date:** _____



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DISABILITY VERIFICATION GUIDELINES FOR MEDICAL PROVIDERS

To ensure timely review of applications, the Blanche Fischer Foundation (BFF) requires medical verification from a qualified medical provider that clearly confirms the applicant's eligibility based on a permanent physical disability. This guide provides clear instructions for writing a compliant verification letter.

Who Can Provide Verification

Acceptable providers include:

- Medical Doctor (MD)
- Nurse Practitioner (NP)
- Physician Assistant (PA)

Note: Letters from individuals who do not meet the above qualifications—such as physical therapists, social workers, chiropractors, or counselors—cannot be accepted.

What the Letter Must Include

Please prepare the letter on your organization's or clinic's official letterhead and include the following information:

Patient/Client Identification

- Confirm that the applicant is under your care.
- Include the applicant's full name and date of birth.

Diagnosis Confirmation

- Clearly state the applicant's medical condition.
- Use the exact phrase: "permanent physical disability."

Impact Statement

- Briefly describe how the condition limits physical functioning or daily activities

Item Necessity (if applicable)

- If the applicant is requesting a specific item (e.g., wheelchair, lift, ramp), confirm medical necessity for the item.

Provider Information and Signature

- Your full name, professional credentials (MD, NP, or PA)
- Practice or clinic name and address
- Phone number
- Signature and date

Common Reasons Letters Are Rejected

- Letter not on official letterhead
- Letter not signed by medical provider
- Missing provider credentials
- Fails to state "permanent physical disability"
- Issued by an unqualified provider
- Does not mention medical necessity of requested item (when applicable)

This verification letter is a required part of the applicant's grant application. Please provide the letter directly to the applicant so they can include it with their completed submission to the Blanche Fischer Foundation.