

**All previous versions of this application are null and void.**

Application#: \_\_\_\_\_

Voucher#: \_\_\_\_\_

Name: \_\_\_\_\_

Check#/CC: \_\_\_\_\_

**Blanche Fischer Foundation**

4931 SW 76<sup>th</sup> Ave #346 <> Portland, Oregon 97225

Phone: 503-246-4941 <> Website: [www.bff.org](http://www.bff.org)

The Blanche Fischer Foundation is a private, nonprofit charitable organization founded in 1981 to assist low-income Oregon residents who have a **permanent physical disability**. (We use 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, etc)  
Daily living expenses (food, utilities, etc)  
Entertainment/recreation expenses  
Gym memberships  
Educational expenses  
Medical/Dental Expenses  
Purchase of a car or van  
Remodel of owner-occupied homes

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  
Travel Expenses  
Car repairs if mass transit is available

**Please Read Carefully (All instructions must be followed. Incomplete or inaccurate applications will delay processing.)**

- 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.
- Applications are reviewed and grants awarded on a quarterly basis by the Grant Review Team. **There is no guarantee of funding.**
- Verification of disability.
  - A letter from a healthcare provider verifying the disability must be included with the application.
  - The letter must state that the applicant has a permanent physical disability and must list the physical disability.
  - Listing “medical condition or health impairment” is not sufficient.
  - **An SSDI Notice is not accepted as verification.**
  - **A form letter is not accepted as verification.**
  - **Medical records are not accepted as verification AND will be shredded.**
  - For the purposes of the application, accepted healthcare providers are:

- Physicians, Nurses, Nurse Practitioners, Physician Assistants, Naturopathic Physicians, or Physical Therapists working within their discipline.
- Only permanent physical disabilities are qualifying conditions. Mental health disabilities are not eligible. Please do not include information about your mental health.
- In requests for a portable air conditioner, recliner, household item, medical device, or item to treat a medical condition, a statement signed by a healthcare provider must accompany the application verifying the device is a **medical necessity**. Stating that “the patient will benefit from the device” is not accepted as proof of medical necessity. Give the attached instructions to your healthcare provider.
- Payment is made to vendors. Direct cash assistance to applicants 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 the submission of the application.
- Applications must be received and include all required documentation by the end of the month in January, April, July, and October. Applications will be reviewed, 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.
- 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.

**Please Read Before Signing**

***By signing this form, you are attesting that you have read the grant application in its entirety. 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)

## Applicant Information

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ County

Telephone/TTY: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

A. Have you received an award from us in the past? Yes \_\_\_\_\_ No \_\_\_\_\_ What Year? \_\_\_\_\_

B. Have you applied to another organization for help in purchasing the item requested in this application?

Yes \_\_\_\_\_ No \_\_\_\_\_

From whom? \_\_\_\_\_ How much? \$ \_\_\_\_\_

C. Have any applications submitted to other organizations for this item been approved?

Yes \_\_\_\_\_ No \_\_\_\_\_ Under Review \_\_\_\_\_

By whom? \_\_\_\_\_ In what amount? \$ \_\_\_\_\_

## Information About Your Disability

8. 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): \_\_\_\_\_

Total 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) \_\_\_\_\_

## 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.**

|   |  |
|---|--|
| <b>MONTHLY INCOME</b>   |  |
| 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   |  |
| <b>A. TOTAL INCOME</b>  |  |
| <b>MONTHLY EXPENSES</b>   |  |
| 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   |  |
| <b>B. TOTAL EXPENSE</b>   |  |

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

(Purposely left blank)

## **Give these instructions to your healthcare provider.**

### **Instructions for verification of physical disability**

1. DO NOT SEND MEDICAL RECORDS. They will be shredded upon receipt.
2. State that the applicant is your patient/client.
3. State that your patient/client has a permanent physical disability. Please use these words.
4. Phrases such as “medical conditions” are not accepted as verification of a permanent physical disability.
5. List the disability.
6. You are free to list additional factors that you consider relevant. However, they may not be used in place of verifying the physical disability.

### **Instructions for verification of medical necessity.**

1. In cases of requests for common household items, such as air conditioners or recliners, you must state that they are a medical necessity.
2. Phrases such as “will benefit from” are not accepted as verification of medical necessity.
3. Comfort is not an accepted reason for awarding a grant.
4. In the case of an air conditioner, not being able to get to a cooling center is accepted as a reason for awarding a grant. Difficulties caused by the pandemic are taken into consideration.
5. We do not award grants for replacing worn items if there is no statement from a healthcare provider stating that the item requested is a medical necessity.

We do not accept medical records or documents from the Social Security Administration as verification of a disability.

Note that we do not need a long letter. A longer letter expanding on the basic requirements listed above is optional.

If you have any questions regarding verification of disability, please call me at 503-246-4941. I received HIPPA training. No one has access to my files or my phone, so privacy is assured.

Thank you.

Sheila Barnhart  
Office Administrator