Application#: _______________ Voucher#: _____________

Name: ______________________________ Check#/CC: _____________

Blanche Fischer Foundation

4931 SW 76th Ave #346 <> Portland, Oregon 97225
Phone: 503-246-4941<> Website: 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)
Daily living expenses (food, utilities)
Entertainment/recreation expenses
Gym memberships
Educational expenses
Dental Expenses
Purchase of a car or van
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
Repair of automobile 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.**
    - 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. To maintain your privacy, 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.

- 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.*

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	
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

(Purposely left blank)

These instructions may be given to your healthcare provider.

Instructions for verification of physical disability

1. State that the applicant is your patient/client.
2. State that your patient/client has a permanent physical disability. Please use these words.
3. Phrases such as “medical conditions” are not accepted as verification of a permanent physical disability.
4. List the disability.
5. 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