Blanche Fischer Foundation

2025 INDIVIDUAL GRANT APPLICATION

INTRODUCTION

Thank you for your interest in applying for a grant from the Blanche Fischer Foundation. Our mission is to provide financial assistance to individuals with permanent physical disabilities to improve their independence and quality of life. This application is designed to gather the necessary information to evaluate your request. Please read the instructions carefully and complete all sections. Incomplete applications may delay processing.

If completing this application by hand, please write legibly. Illegible applications will not be considered.

What you will need to complete this application:

- A copy of your Oregon State ID, Driver's License, or Military ID.
- An advocacy statement from a professional.
- A medical verification letter from a qualified health professional.
- Demonstration of Engagement
- Supporting documents such as vendor estimates for requested items.
- Details required to complete the Income and Expenses Worksheet, including accurate income and expense information for yourself and all household members.

ADVOCACY AND SUPPORT VERIFICATION

The Blanche Fischer Foundation encourages applicants to seek assistance from an advocate to ensure the application reflects an accurate and thorough assessment of the requested need. An advocate can be a professional (e.g., representatives from Centers for Independent Living, caseworkers, or rehabilitation counselors) or a family member who is familiar with the applicant's circumstances and can assist in completing the application accurately.

- Name of Advocate: ____
- Relationship to Applicant (e.g., family member, professional): ________________________
- Organization Name (if applicable): ____
- Contact Information (Phone/Email): ____
- Duration of Relationship with Applicant: ____
- Brief Statement of Advocacy (to be completed by the advocate):

(Example: I have reviewed the applicant's request for funding to purchase a wheelchair and confirm that this equipment is essential to improving their mobility and independence. I have worked with the applicant for the past 2 years and can attest to the challenges they face daily. Based on my experience and interaction with the applicant, I believe this need is genuine and will provide long-term benefits.)

The advocate is encouraged to verify that the application is realistic, complete, and clearly outlines the applicant's needs. Advocates are also encouraged to use official letterhead if applicable, but this is not required.

[ ] I confirm that I have reviewed the application for accuracy and completeness.

[ ] Advocacy Statement is included with this application.

Signature of Advocate: ____

MEDICAL VERIFICATION

Applicants must provide a verification letter from a qualified medical professional. This letter is a critical component of the application process and ensures that the requested assistance is medically necessary and supports a permanent physical disability. **Applications without this letter cannot be considered. Letters must be on official business letterhead.**

Who Can Provide Verification:

- Physicians (MD, DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Licensed Occupational or Physical Therapists
- Clinical Social Workers (LCSW) familiar with the applicant's condition
- Psychologists or Psychiatrists (for disabilities impacting physical function)

Instructions for Medical Professionals:

1. **State Patient/Client Relationship**: Indicate that the applicant is your patient or client and specify how long you have been treating them.
2. **Verify Permanent Physical Disability**: Use the exact phrase "permanent physical disability" to confirm the applicant's condition and duration of condition.
3. **Describe the Disability**: Clearly name the specific disability and explain how it limits the applicant's physical abilities or daily activities.
4. **Confirm Medical Necessity**: Provide a detailed explanation of why the requested item(s) are medically necessary, including how they address the applicant's impairment or improve their quality of life. Avoid vague phrases like "will benefit from," as these do not meet the verification criteria.
5. **Comfort-based Requests**: Note that requests based solely on comfort are not eligible.
6. **Optional Additional Information**: You may include additional factors to support the request, but these cannot replace the required verification.

(Example Statement: John Doe is my patient. He has a permanent physical disability. The disability is paraplegia. Because of this condition, the requested wheelchair is a medical necessity and will improve his independence and quality of life.)

[ ] Medical Verification is included with this application.

DEMONSTRATION OF ENGAGEMENT

The Blanche Fischer Foundation values applicants who actively strive to improve their independence and quality of life. Please provide details about your engagement in activities that reflect these efforts. This section helps the Foundation understand how the requested assistance aligns with your ongoing pursuits.

Examples of Demonstration of Engagement:

- Participation in **rehabilitation programs**, such as physical therapy, occupational therapy, or counseling.
- Enrollment in **educational programs** or pursuing certifications to improve skills.
- Engagement in **employment opportunities**, either part-time or full-time, or active job-seeking efforts.
- Volunteering with local organizations or in your community.
- Active involvement in **support programs**, including peer support groups or mentoring others.
- Commitment to **health management plans**, such as attending regular medical appointments, maintaining therapy regimens, or adopting assistive technologies.

Please complete the following:

1. **Describe your current activities that demonstrate engagement:**
   (Example: "I am actively participating in a physical therapy program twice a week to improve my mobility and have completed an online course on adaptive living strategies.")

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2. **How do these activities support your independence or quality of life?**
   (Example: "These activities have allowed me to regain strength, enabling me to perform daily tasks more independently.")

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3. **List any organizations, programs, or support groups you are involved with:**
   (Example: "Local peer support group for individuals with disabilities, Adaptive Sports Northwest.")

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4. **Provide any supporting documentation or references to validate your efforts (optional but encouraged):**
   - Documentation might include program enrollment letters, therapy attendance records, or letters from mentors or instructors.

[ ] Supporting documentation is attached to this application.

APPLICANT INFORMATION – MUST BE LEGIBLE

Personal Information

Name: ____

Address of Residence: ____

- City: _________________________ State: _______ Zip: ___________
- County: ____

Mailing Address: ____

- City: _________________________ State: _______ Zip: ___________
- County: ____

Date of Birth: _________________________

Age: ____________________

Contact Information

Telephone/TTY: (____)____________________

Email: ____

Best Form of Contact: [ ] Email [ ] Text [ ] Phone

If applicant is a minor:

Parent/Guardian Name(s): ____

HOUSEHOLD INFORMATION

Total Number of People in Household: __________

Adults: __________ Children: __________

Relationship(s) of Other Adults in Household: ____

Number of Wage Earners in Household: __________

Number of Social Security Recipients: __________

Occupations of Household Members: ____

INFORMATION ABOUT YOUR DISABILITY

Brief Description of Your Physical Disability: *(Example: I have paraplegia, which limits my mobility and requires the use of a wheelchair.)*

How long have you had this condition?

Is your condition permanent?

What limitations do you experience because of your disability? *(Example: I am unable to stand, walk, or perform certain daily activities independently.)*

For what specific item or assistance are you requesting funding?

How will this grant improve your quality of life or functioning? *(Example: A motorized wheelchair will allow me to move around independently and complete daily activities with ease.)*

What steps have you taken to manage your disability and improve your independence

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- Cost of Requested Item: $__________
- How much are you able to contribute to the cost? $__________
- How much are you requesting from the Blanche Fischer Foundation? $__________

Have you sought funding from other resources for this request? ____________________________

Please describe any efforts to obtain funding from other organizations or resources for this item and include any supporting documentation as applicable.

Is there anything else you'd like us to know about your situation?

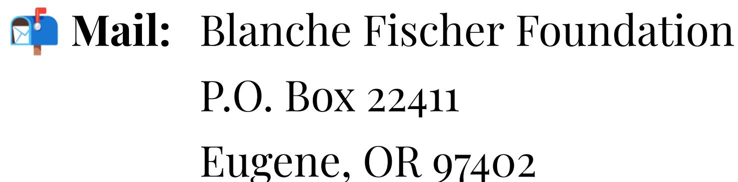
APPLICATION CHECKLIST

Before submitting your application, please ensure you have included the following required documents:

- ☐ Completed, Signed, and Dated Application
- ☐ Advocacy Statement
- ☐ Medical Verification Letter (on official letterhead)
- ☐ Demonstration of Engagement (supporting documents)
- ☐ Proof of Residency (Oregon State ID, Driver's License, or Military ID)
- ☐ Vendor Estimates for the requested item(s)
- ☐ Completed Income and Expenses Worksheet – See attached worksheet

SUBMIT YOUR COMPLETED APPLICATION:

📧 **Email:** Send your application to grants@bff.org



📬 **Mail:** Blanche Fischer Foundation
P.O. Box 22411
Eugene, OR 97402

For any questions, please contact us at grants@bff.org.

CERTIFICATION AND AGREEMENT

By signing below, I certify that:

1. I have read and understand the Blanche Fischer Foundation grant process.
2. The information provided in this application is accurate to the best of my knowledge.
3. I understand that any errors or omissions may result in the denial or cancellation of the grant.
4. If awarded, payment will be made directly to the vendor and not to me. Any refunds will be the property of the Foundation.
5. All grant decisions are at the sole discretion of the Blanche Fischer Foundation and are final.
6. Grantee information (name and address) may be a matter of public record as part of the Foundation's federal tax filings.

Applicant Signature: ____

Print Name: ____

Date: ____

If prepared by someone other than the applicant:

Name: ____

Blanche Fischer Foundation - INCOME and EXPENSES WORKSHEET

Note: All household members' gross income must be listed, regardless of source. More than two earners attach sheet

MONTHLY INCOME - attach copies of income statements	Primary Earner	Secondary Earner
Social Security Benefits (List Medicare deductions under Expenses)		
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:		
A. TOTAL MONTHLY INCOME		
MONTHLY EXPENSES		
Housing Rent, Mortgage (circle one)		
Housing Property Taxes		
Housing Utilities		
Food/Groceries		
Transportation - Auto Insurance		
Transportation - Car Payment		
Transportation - Public Transportation - Bus Passes		
Insurance - Health		
Insurance - Other, Specify:		
Medical - Co-pays		
Medical - Pharmaceuticals		
Medical - Durable Medical Equipment operational expense		
Medical - In-home care		
Other Expenses, Specify:		
B. TOTAL MONTHLY EXPENSE		

I certify, 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. (Guardians sign for dependents)

Signature ____________________ Print Name ____________________ Date __________