



# PLAN OF CT CHARITABLE TRUST

## Guidelines for Requests (Adult)

### WHO DOES PLAN'S CHARITABLE TRUST SERVE?

The PLAN of CT Charitable Trust is a fund of need-based assistance that can temporarily help **Connecticut residents with disabilities**. Some individuals may be profoundly affected by their disability; others may be nearly independent but need some critical support.

### WHAT REQUESTS DOES THE CHARITABLE TRUST SUPPORT?

Charitable Trust distributions that are covered by the trust are varied. Past distributions include:

- Vehicle or home modifications
- Adaptive equipment and technology
- Music or art therapy
- Advocacy and educational services

### THE APPLICANT MUST PROVIDE:

- **Proof of a disability** (*Disability Determination Letter from State, or SSDI payment stub/proof of direct deposit, or Doctor's Note meeting SSA standards for those only 65+ ~ form available upon request*)
- **Completed income/expense form** (page 3) (*Applicants with limited income/assets given priority*)
- **Recent Bank Statement or Tax Return** (*Must show financial need*)
- **Proof of ownership of home/vehicle** (*If request is for home or vehicle improvement*)
- **Invoice from vendor with costs** (*Two quotes are needed for home/vehicle installation services*)

### THE CHARITABLE TRUST DISTRIBUTION STIPULATIONS:

- May not interfere with public benefits or supplant available public benefits
- May not be towards a debt payment or service already rendered
- PLAN of CT pays vendors directly via check for services and goods, cash is not awarded.

### HOW DOES THE SELECTION PROCESS FOR REQUESTS WORK?

- Our trust committee meets on the second Thursday of each month to review applications.
- Submitting a request prior to the meeting does not guarantee request approval.
- Incomplete applications cannot be reviewed until required documents are provided.
- We will mail you a committee decision letter the week following the meeting.

### PLEASE COMPLETE AND SEND TO THE OUTREACH COORDINATOR AT:

**MAIL:** PLAN of CT, P.O. Box 290937, Wethersfield, CT 06129

**FAX:** (860) 523-0267

**EMAIL:** info@planofct.org

## CHARITABLE TRUST APPLICATION (Adult)

<b>Request:</b>	<b>Amount:</b>
<b>Contact:</b> <i>(if not applicant)</i>	<b>Relationship to Applicant:</b>
<b>Phone:</b>	<b>Email:</b>
<b>Applicant Name:</b>	<b>Birthdate:</b>
<b>Street Address:</b>	<b>City, State, Zip Code:</b>
<b>Disability:</b>	<b>Date of Request:</b>
<b>Benefits:</b> SSA   SSI   SSDI   Medicare   Medicaid <i>(Please circle all that apply)</i>	<b>Number of People in Household:</b> Adults _____ Children _____

For your request to be considered you must first submit all of the following:

- **Proof of disability for applicant, invoice from a company for the requested amount, proof of income, and a completed monthly income/expense form.** (Please see guidelines on page 1)

**1. What benefit will this requested item or service have on the everyday life of the applicant?**

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**2. What goal(s) will the applicant reach with our assistance? *If the request for support is for a duration of time (i.e. six weeks) please mention the benefit of that particular duration chosen.***

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**3. Is this an ongoing financial need for the applicant?   **Yes / No****

What financial resources do you plan to use to cover future or remaining costs of this request?

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**4. Have you applied for a grant with any other organization(s) for this request?   **Yes / No****  
 If yes, which organization(s) and for how much?

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**5. How did you hear about PLAN's Charitable Trust?** \_\_\_\_\_

**CHARITABLE TRUST APPLICATION (Adult)**  
**MONTHLY EXPENSES AND INCOME**

**Estimated Expenses**

**Estimated Income**

Rent/Mortgage:	\$ _____	Wages (Gross):	\$ _____
Gas/Oil Utility:	\$ _____	Disability Income (SSDI):	\$ _____
Electric Utility:	\$ _____	Social Security (SSA or SSI):	\$ _____
Phone Bill:	\$ _____	Unemployment:	\$ _____
Food:	\$ _____	SNAP:	\$ _____
Medical: <i>(equipment, supplies, copays)</i>	\$ _____	TANF:	\$ _____
Insurance - Medical:	\$ _____	Child Support:	\$ _____
Insurance - Auto:	\$ _____	Alimony:	\$ _____
Transportation: <i>(Gas, bus pass, etc.)</i>	\$ _____	Pension:	\$ _____
Misc. _____:	\$ _____	Cash Assistance:	\$ _____
Other _____:	\$ _____	Other _____:	\$ _____

\_\_\_\_\_ - \_\_\_\_\_ = **Net Monthly Income: \$ \_\_\_\_\_**  
*Total Income*                      *Total Expenses*

***\* In order for our committee to review your request, we must have a completed application with all required documents prior to our monthly committee meeting. \****