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. **Ask our Outreach Coordinator about specific requests not listed here.**
Past distributions include:

- Vehicle or home modifications
- Music or art therapy
- Adaptive equipment and technology
- 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*)
- **Proof of home ownership** *(mortgage statement/property tax bill)* **or landlord approval letter if seeking home installation services while renting.**

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 *or*
FAX: (860) 523-0267 *or*
EMAIL: info@planofct.org

CHARITABLE TRUST APPLICATION (Adult)

Request: *(good/service)*	**Amount:** *(Cost)*
Contact: *(if not applicant)*	**Relationship to Applicant:**
Phone:	**Email:**
Applicant Name:	**Birthdate:**
Street Address:	**City, State, Zip Code:**
Disability:	**Date of Request:**
Benefits: SSA SSI SSDI Medicare Medicaid *(Please circle all that apply)*	**Number of People in Household:** Adults______ Children_________

For your request to be considered you must answer ALL questions and ALSO submit:

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?**

____

____

____

____

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.*

____

____

3. **Is this an ongoing financial need for the applicant? Yes / No**
   If yes, what financial resources do you plan to use to cover future/remaining costs?

____

____

____

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? *(Proof of pledges are required.)*

____

____

____

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/Internet/Cable:	$__________	Unemployment:	$__________
Food:	$__________	SNAP:	$__________
Medical: (*equipment, supplies, copays*)	$__________	TANF:	$__________
Insurance - Medical:	$__________	Child Support:	$__________
Insurance - Auto:	$__________	Alimony:	$__________
Transportation: (*Gas, bus pass, etc.*)	$__________	Pension:	$__________
Misc. ________________:	$__________	Cash Assistance:	$__________
Other________________:	$__________	Other______________:	$__________

________________ - ________________ = **Your Net Monthly Income: $____________**

Total Income ***Total Expenses***

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