PLAN of Connecticut

Live for today.
We'll plan for tomorrow.

SPECIAL NEEDS FOCUSED TRUST MANAGEMENT

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 one time, needs-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 grants are varied. **Ask our Outreach Coordinator about specific requests not listed here. Past grant distributions include:**

- Vehicle or home modifications
- Music or art therapy
- Autism robots
- Adaptive equipment/technology
- Advocacy or educational services
- Braille books

THE APPLICANT MUST PROVIDE THIS COMPLETED APPLICATION AND:

- **Proof of a disability** *(Disability Determination Letter from State, or SSDI payment stub/proof of direct deposit, or a Doctor's Note meeting SSA standards for ages 65+ ~ form available from PLAN upon request*)
- **Recent bank statements for all accounts or recent tax return** *(This is proof of financial need)*
- **Invoice(s) from vendor(s) with cost** *(Two quotes are needed for home/vehicle installation services*)
- **Proof of ownership of vehicle** (*If request is for vehicle modifications)*
- **Proof of home ownership** *(mortgage statement/property tax bill)* **or landlord approval letter for renters seeking any home installation services.**

THE CHARITABLE TRUST DISTRIBUTION STIPULATIONS:

- May not interfere with public benefits or supplant available public benefits.
- May not be an emergency request, we review applications monthly.
- May not be towards a debt payment or service already rendered prior to applying.
- 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 ALL 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 below & 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(s) will this requested item/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?

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. ****