VCIL Vermont Center for Independent Living

People with disabilities working together for dignity, independence, and civil rights

Sue Williams Freedom Fund Application

IMPORTANT:

*Are you in a nursing home? Yes ___ No ___

*Do you receive Choices for Care Services? Yes ___ No ___

If yes, who is your case manager? _____

*Does your disability prevent you from taking care of your children? Yes_ No_

SWFF Goals – LIMIT ONE:

__ Vehicle modifications __ minor home modifications (grab bars)
__ therapeutic mattress __ adaptive fire/CO2 alert systems
__ adaptive child monitors __ air conditioner, prescribed by doctor
__ food preparation appliances with VCIL Meals on Wheels agreement
__ Mobility aid (scooter, lift chair, etc.) What is it? _____
__ co-payment for prosthetics __ dentures __ eyeglasses
__ Housing transition assistance when transitioning from a nursing home, avoiding nursing home placement or to maintain parental rights

OTHER: _____
_____

Name: _____ DOB: _____ County: _____

Cell: _____ home: _____ Email: _____

Physical address: _____ City_____VT Zip _____

Mailing address: _____

Emergency contact*: _____ Phone: _____

Your relation to emergency contact: _____Email: _____

Case manager name*: _____ Tel: _____

Case manager email address: _____

*VCIL has my permission to contact these people for this application

11 East State Street, Montpelier, VT 05602
802-229-0501, 800-639-1522 (voice & TTY), fax: 802-229-0503
email: info@vcil.org • website: www.vcil.org

What are your specific disabilities? (Ex: multiple sclerosis, arthritis)

_____

_____

Please tell us how receiving this assistive technology device will help you increase your independence and how it relates to your disability:

_____

_____

_____

Living Arrangements:

☐ Independent ☐ With Personal Care Service ☐ Homeless
☐ Other - please explain: _____

Annual Household Income $_____ Please list everyone living in household and list ALL household income. Send copies of benefit statements, tax returns, or bank statements.

Household Members Information (use back of page if more than 4 in household)

Name	Age	Relationship	Income Amount
		Self	$

THE PART YOU PAY:

If the item is less than $1,500.00, you pay 20% of the cost.
If the item is $1,500.01 to $1,800.00, you pay $300.00
If the item is $1,800.01 or more, you pay all amounts over $1,500.00

IMPORTANT: The Sue Williams Freedom Fund **cannot reimburse you for any assistive technology you have already purchased.** We can only pay for expenses that have been authorized VCIL.

**Please initial here that there are no reimbursements:_____*

The Applicant certifies all information in this application and all information given in this application and is true and complete to the best of the Applicant's knowledge and belief.

_____ _____

Applicant Date VCIL Program Coordinator Date

In order for your application to be considered complete, you must attach these items:

- ❑ Consumer Eligibility Form
- ❑ Release of Information
- ❑ Information on Confidentiality and Appeals
- ❑ Income verification
- ❑ Letter/note from your doctor about how your disability relates to this item
- ❑ Price and vendor information for item you wish to purchase through SWFF

OPTIONAL: Gender: _____ Ethnicity: ☐Hispanic/Latino ☐Other
Race: ☐White ☐Black/African American ☐American Indian/Alaskan Native
☐Native Hawaiian/other Pacific Islander ☐Asian

Are you a Veteran? Y/N
Are you registered to vote? Y/N If no, would you like to register? Y/N

Do you receive 3SquaresVT? Y/N If no, would you like to apply? Y/N

The information regarding race, ethnicity, and sex designation solicited on this application is requested in order to assure the Federal Government, acting through the Rural Housing Service that the Federal laws prohibiting discrimination against tenant applications on the basis of race, color, national origin, religion, sex, familial status, age and disability are complied with. You are not required to furnish this information, but are encouraged to do so. This information will not be used in evaluating your application or to discriminate against you in any way. However, if you choose not to furnish it, the service provider is required to note the race, ethnicity, and sex of individual applicants on the basis of visual observation or surname.

The Vermont Center for Independent Living is an Equal Opportunity Employer
Equal Housing Opportunity

SWFF Release of Information

The Vermont Center for Independent Living (VCIL) has an obligation to keep your personal information, identifying information, and records confidential. However, VCIL will need to share some of your information to determine eligibility for the Sue Williams Freedom Fund (SWFF).
I understand VCIL may share my name, contact information, medical condition, and financial information with one or more of the following entities:

Access Mobility/Amramp	Dental office/Medical store
Lowes	Amazon
Furniture store	Other:

I authorize VCIL to contact the medical professional serving my physical needs:

_____ _____
(Print Name of Medical Professional) (Med Professional's Phone)

I understand:

My information may be shared by phone, fax, mail, or e-mail.

_____
(please initial)

I do not have to sign a release form, but I understand that not signing this form may result in being ineligible for SWFF.

_____
(please initial)

Releasing information about me could give another agency or person information about my location and confirm that I have been receiving services from VCIL.

_____
(please initial)

I, _____,understand that this release is valid
(Print Applicant Full Name)

when I sign it and that I may withdraw my consent at any time either orally or in writing.

Signed:_____

Date:_____

This form expires one year after date of signature

Consumer Eligibility Form

To be eligible for Vermont Center For Independent Living services, a person must experience a significant disability which limits their ability to function independently. In order to document that you are eligible for our services, please answer the following questions,

I, _____, state that I have one or more of the following the following disability types (circle all that apply):

Cognitive Deaf Mental/Emotional Physical Vision Other (specify)

Date of Birth _____

Town of Residence _____

My disability(ies) substantially limits me from functioning independently in the following area(s):

___self-care
___mobility
___education
___employment
___housing
___Other (specify): _____

The services I am requesting will help me: (Check all that apply)

___improve my ability to function in my family or community
___maintain my ability to function in my family or community
___obtain, maintain or advance in employment

I understand that it is my choice to have services provided to me under an Independent Living Plan (a formal plan which states my goals and services I will receive) or I can choose not to have such a plan (Waiver). I choose:

___ Independent Living Plan ___ Waiver

_____ _____

Consumer's Signature Date

By signing below, I determine as a representative of the service provider that the applicant is eligible for services and has met the basic requirements specified in Section 364.40. The consumer has received information about the Client Assistance Program (CAP).

_____VCIL Signature _____VCIL Date

NORTH SOUTH

Information on Confidentiality and Appeals

Confidentiality

VCIL works to keep records confidential. You may be asked to sign a "Release of Information" form that will allow the staff of the Sue Williams Freedom Fund (SWFF) to work with partner organizations. You will also be asked to share documentation to help determine your eligibility for the program. This information will be held confidential by VCIL staff.

On occasion, VCIL is audited by the federal and state government, who are funders of the SWFF. These audits include looking at peer files. This information will not be shared publicly, but there is an expectation that VCIL allow auditors to look at our records.

VCIL does not discriminate on the basis of race, national origin, religion, marital status, gender, sexual orientation, age and/or disability.

Appeals

VCIL has a grievance procedure. If you believe you have been discriminated against or want to file a grievance because you believe you were treated unfairly, please contact the coordinator of the SWFF Program or their direct supervisor the Deputy Director for information on how to file a grievance.

If you would like assistance from someone other than a staff member of VCIL to help you file a grievance you can contact the Client Assistance Program (CAP). The Client Assistant Program address is 57 North Main Street, Rutland, VT and their toll free phone number is 1-800-889-2047 (V/TTY).

I am signing this document to acknowledge I've received this information.

_____ _____

Signature of Participant Date