

# **The Cindy Donald Dreams of Recovery Foundation, Inc.**

## **Application for Financial Assistance**

### **General Information**

The Cindy Donald Dreams of Recovery Foundation was established to assist individuals with paralysis due to spinal cord or brain injuries in receiving continued therapeutic exercise to promote neurological recovery, maintain health and fitness, and enhance quality of life. We strive to help individuals receive the assistance or equipment necessary to continue therapeutic exercise. Through knowledge and experience, we also strive to promote awareness and advance research for the cure of paralysis.

People who have traumatic brain or spinal cord injuries may apply for funding to assist them in meeting any or all costs of receiving therapy or equipment that will promote neurological recovery. Applications for funding may be submitted at any time and will be reviewed by the Foundation Board of Directors at the Board's quarterly meetings.

### **Eligibility Requirements**

#### **Who is eligible for financial assistance?**

- Financial assistance is only available to US citizens. You must furnish evidence of citizenship (e.g., birth certificate or passport).
- Applicants must have experienced a traumatic or non-traumatic brain or spinal cord injury resulting in paralysis that substantially interferes with personal independence. You must have a letter from a physician, medical practitioner, hospital clinic or other medical or medically-related facility, or insurance company verifying the nature (type) and cause of your injury.
- There is no age requirement.
- Applicants must submit verification from a therapist, exercise instructor, or other service provider that there is potential for therapeutic benefit from the proposed exercise program or equipment.
- Applicants must also demonstrate financial need and must submit documentation to substantiate need. This documentation must verify that the requested funding is outside the scope of other funding sources or is not otherwise available within existing community resources or through other agencies or programs.
- Eligibility for funds DOES NOT confer any entitlement to an award.

#### **How can funds be used?**

- Funding from the Cindy Donald Dreams of Recovery Foundation may be used to offset the cost of therapeutic exercise programs or equipment provided by a legitimate vendor of such services or equipment.
- Acceptable therapies include integrative manual therapy (IMT); physical therapy; therapeutic exercise delivered by a fitness instructor, licensed personal trainer, or other licensed/certified provider.

- Applications will be considered for other care and rehabilitative services if the requests otherwise meet the criteria for approval.
- Funds may also be used to purchase exercise equipment (e.g., FES bike) or to pay membership fees for a YMCA or other fitness center or gym.
- Cost estimates and quotes from vendors must be included in the Application. Costs for services or goods must be in line with costs the Foundation has identified. Costs that are unusual or exceed the expected costs must be explained to the satisfaction of the selection committee.
- Payment will only be made to acceptable vendors or other third party recipient. Payment WILL NOT be made to the individual receiving benefits of the award.
- The Foundation should always be a payor of last resort. The funds should not be used to displace other sources of funding.

## **General Funding Guidelines**

These are the guidelines the Commission uses to select, prioritize and review funding requests. Please read to see if your request fits.

- The Foundation is not a permanent source of funding. We encourage you to develop a plan for how you will be able to meet your long-term needs.
- Funding will be distributed to those who are most in need. Requests for funding are assessed according to criteria set forth in the Foundation's Distribution Policies, including potential to benefit, need for support, and personal and outside resources available.
- All distributions are subject to the availability of funds.
- Outstanding medical bills, medical insurance premiums, and medication costs will not be considered.
- All requests for therapeutic services or equipment will be evaluated according to their potential outcome. The provider of services must provide clear, measurable goals for therapy tailored to the applicant's objectives.

## **Frequently Asked Questions**

To assist those who are interested in applying for financial assistance, the following questions may help you decide whether to apply and what you can expect if you apply.

### **1. Can an individual apply directly to the Foundation for financial assistance?**

Yes, you may apply directly. Anyone interested in receiving financial assistance must fill out an application and submit it and other required documents to the Foundation.

### **2. What if I am not able to complete the application?**

You may have someone complete the application on your behalf. It may be a family member, a friend, or a guardian.

**3. Is there a deadline to submit the application?**

No. Applications are taken on an on-going basis. However, decisions about funding are made quarterly at meetings of the Foundation Board of Directors.

**4. How long will it take to review my application?**

If your application is complete, we anticipate that this process will take ten or more weeks from the date of receipt of your application. If your application is incomplete, it may be necessary to contact you to gather additional information, which may delay this process. The final step of the process is for the Selection Committee to send their recommendations for funding to Foundation Board of Directors, who select applications for funding at their quarterly board meetings.

**5. If I am approved for assistance, when will I receive the funds?**

Once you have been approved for funding, you will need to complete some additional paperwork and send it back to us. The paperwork indicates the provider you have chosen and the specifics of the good or service to be provided. The provider will then receive an authorization to provide the good or service. The provider must submit an invoice to us for the good or service rendered. Upon receipt, it will take approximately 2 to 3 weeks to issue a check for the funds. The length of the process will depend on how quickly the paperwork is returned to us, and how quickly you and the provider you've chosen are able to coordinate.

**6. How much money can I apply for?**

It is anticipated that no award will be made for more than \$15,000 per applicant.

**7. Will the check be made out to me or to the provider?**

Unless otherwise approved by the Foundation Board, the check will be made out to the provider. Should you receive the funding directly, you will need to determine the legal effects of receipt of financial assistance from the Foundation on other benefits.

**8. Can the Foundation reimburse me for past expenses?**

No. The Foundation will not pay for goods and services that have already been rendered or delivered at the time of the application.

**9. If I have applied before and want to apply again, do I have to complete the entire application again?**

Yes. You will need to complete a new application with information related to your new request.

**10. Do I have to use a specific provider or can I choose my own?**

You may choose your own provider. The Foundation may seek basic information about the provider's ability to deliver the good or service.

**The Cindy Donald Dreams of Recovery Foundation, Inc.**  
**Application Form**

Please complete all pages and questions on the application

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

\*\* Please attach a photocopy of your Birth Certificate or US Passport \*\*

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Person Completing Application (if different from Applicant) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

How did you hear about The Cindy Donald Dreams of Recovery Foundation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nature of Injury (Check all that apply):

\_\_\_\_ Brain Injury

\_\_\_\_ Spinal Cord Injury

Level of Injury? \_\_\_\_\_

ASIA Classification? \_\_\_\_\_

Date of Injury \_\_\_\_\_ Please describe how your injury occurred:

\_\_\_\_\_

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The Cindy Donald Dreams of Recovery Foundation is intended to be the funding source of last resort. Other funding sources are often available for requests such as computers, assistive technology, adaptive equipment, etc. Accessing these funding sources will maximize the dollars available to you. Please document below, other funding sources you have applied to for assistance and the status of assistance provided:

Awaiting Eligibility	Eligible & Enrolled	Have applied but not eligible	Not Applicable
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**Personal Support Services**

Community Care Services (CCSP)  
Independent Care Waiver Program (ICWP)  
SOURCE Waiver

**Financial Resources**

Medicaid  
Medicare  
SSI  
SSDI  
Private Insurance  
Short Term Disability  
Long Term Disability  
Vocational Rehabilitation (VR)  
PASS Plan  
Indigent Care Trust Fund  
Veteran's Administration

**Other Funding sources**

Centers for Independent Living  
Victims Compensation Fund  
Friends of Disabled Adults & Children  
Assistance Technology Resource Centers

What is your current monthly income from all sources? \_\_\_\_\_

Are you currently living in a nursing facility, group home, personal care home, or other facility?

Yes No

If yes, please describe \_\_\_\_\_

If living in your own home, who do you live with? \_\_\_\_\_

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Do you require personal assistance services? Yes No

If yes, how many hours per day and who provides these services?

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Do you have transportation available when you need it? Yes No

What source and who pays for it? \_\_\_\_\_

\_\_\_\_\_  
Please describe briefly how the funds you are requesting will be used. What goods or services will be purchased; how will they benefit you; how will they improve your independence? What is the total amount of funding you are requesting (cannot exceed \$37,222)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How will financial assistance allow you to be more a part of your community?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the service or good you are requesting cost more than \$37,222 how will you pay for the remaining costs if you are approved for financial assistance?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there other factors you may wish to be taken into consideration (health factors, living arrangement, financial or family issues)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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In order to be considered, please provide an estimated cost of the equipment or therapy you are requesting. That agency, vendor, or individual provider will provide the requested services or good if funds are approved.

1. Service or Good  
Provided:

Address:

Phone:

Contact Person

2. Service or Good  
Provided:

Address:

Phone:

Contact Person

3. Service or Good  
Provided:

Address:

Phone:

Contact Person

4. Service or Good  
Provided:

Address:

Phone:



Contact Person

- A. By signing below, I certify that:  
I have read and understand the Criteria and Guidelines set by TCDDORF Committee  
I have provided truthful, complete and accurate information on this applicant,  
and  
I have exhausted all other insurance and governmental funding sources before applying to TCDDORF Committee
- B. I represent and assure the Committee that, if I am granted an award, I will:  
Use the funds for the purpose state in this application; and  
Promptly report in writing the TCDDORF any change in the availability of Insurance and Governmental Funding sources that may affect my eligibility for funds.
- C. I understand and acknowledge that:  
TCDDORF has the right to rely on the information contained in this Application or any subsequent amendments; and  
TCDDORF has the right to withdraw or modify any disbursement in the event that:  
The information contained in this application or any subsequent amendment should at any time be determined to be false, incomplete, inaccurate, or misleading, or  
  
The funds are used for a purpose other than stated in this application; or  
  
TCDDORF becomes aware of any change in my status or circumstance that may affect my eligibility, and  
  
It is my responsibility to determine if the receipt of funds legally impacts other benefits that I may receive.

I certify that, to the best of my knowledge and ability, the information included in the application is accurate as of the date signed below. I also acknowledge that I am aware that if I receive The Cindy Donald Dreams of Recovery Foundation award my name or any images may be used by The Cindy Donald Dreams of Recovery Foundation for media and / or promotional purposes.

Signature \_\_\_\_\_

Date \_\_\_\_\_

(For applications submitted by email, this signature page must, in addition, be submitted by hard copy)

## Authorization Form

**By signing below**, I hereby authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to The Cindy Donald Dreams of Recovery Foundation or its designee and its legal representatives.

Any physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company, Third Party Administrator, the Medical Information Bureau or any similar organization, institution or person, any employer, group plan holder, or certificate holder.

If the record released contains information relating to HIV test results, AIDS, alcohol abuse or mental health care, enough of this information is to be released to accomplish the purposes for which the information is requested and to the extent permitted by law.

I understand that the information released to The Cindy Donald Dreams of Recovery Foundation may be used to process my application for disbursement from the Fund and may be given to any person or entity carrying out a function for, on behalf of, or in conjunction with TCDDORF.

This information may also be re-disclosed as otherwise specifically required or permitted by law. This authorization shall remain in effect until revoked by me in writing

Signature \_\_\_\_\_ Date \_\_\_\_\_

For applications submitted by email, this Release/Authorization must, in addition, be submitted by hard copy.