UCP United Cerebral Palsy™
of Nebraska
Life without limits for people with disabilities™

920 S. 107th Ave.
Suite 302
Omaha, NE 68114

(800) 729-2556
(402) 502-3572
FAX (402) 502-6791

www.ucpnebraska.org

Thank you for considering UCP of Nebraska's Client Assistance Grant Program. United Cerebral Palsy of Nebraska uses the Service & Device Application Form. This is a multi-agency form used by numerous agencies (see page 4 of the application).

While UCP of Nebraska will consider any type of request, following are some of the criteria used when reviewing an application: Promotion of independence, Enhancement of mobility, and Assistive Technology.

Funding through UCP of Nebraska is designed for individuals and families of individuals with cerebral palsy or conditions with similar effects that have limited financial resources or do not qualify for other financial support. The table below outlines the income eligibility guidelines.

Number of family members (include parents and children)	***Monthly*** Household Income	***Annual*** Household Income
1	$2,394	$28,725
2	$3,231	$38,775
3	$4,069	$48,825
4	$4,906	$58,875
5	$5,744	$68,925
6	$6,581	$78,975
For each additional person add:	$838	$10,050

You may be asked to provide proof of your income. Each request is reviewed on its own merits by a review committee, which meets quarterly. Funding for approved requests will be made available for six months. Payment will be made directly to the vendor upon receipt of an invoice.

If you have any questions about the application process or other programs and services provided by UCP of Nebraska, please call 1-800-729-2556. We look forward to working with you.

Sincerely,

Anne Brodin

Anne Brodin
Director, Finance and Services

Service and Device Application (Multi-Agency Form)

Date _____

Applicant Information

_____

Last ***First*** ***Middle Initial***

☐ *Male* ☐ *Female*

☐☐☐ ☐☐ ☐☐☐☐

Social Security Number

_____/_____/_____ *(mm/dd/yyyy)*

Date of birth

United States Citizenship Attestation

For the purpose of complying with Neb. Rev. State. §§ 4-108 through 4-114, I attest as follows:

☐ I am a citizen of the United States

or

☐ I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows:

_____

_____

Address

_____

City/State/Zip Code

_____

County

(___)_____

Home Phone

(___)_____

Cell Phone/Work Phone

_____

Email

Person completing form

_____

Name

_____

Relationship to Applicant

_____

Address

_____

City/State/Zip Code

(____)_____

Phone Number

_____

Email

☐ Permission given by applicant for agencies to communicate with person assisting with form

_____ *Initials of applicant*

Referral source (if applicable)

_____

Agency/Organization

_____

Address

_____

City/State/Zip

(____)_____

Phone

_____

Email

Services Coordinator

_____

Name/Agency

Phone (____)_____

Disability

_____

What services or devices are you requesting that would help keep your daily activities safe and independent?

Services/Devices	Estimated Cost

Other Services and Equipment Requested	Estimated Cost
☐ Home Modifications	
☐ Personal Attendant	
☐ Housekeeping Services	
☐ Special Equipment/Assistive Device	
☐ Transportation	
☐ Vehicle Modifications* * Title of vehicle in applicant's name ☐ yes ☐ No	

Housing (Check all that apply)

☐ Home owner
☐ Renter
☐ Mobile Home-permanent foundation ☐ yes ☐ no
☐ Nursing home
☐ Foster Home/adult family home
☐ Group home/community residence
☐ Living with adult/adult children
☐ Homeless
☐ Other _____

Community Assistance Received

(Check all that apply)

☐ League of Human Dignity/Barrier Removal Program.
☐ Housing & Urban Development/Section 203
☐ Making Homes Accessible (MHA)
☐ Rural Development, Section 502
☐ Rural Development, Section 504
☐ Weatherization

Health Insurance

☐ Yes ☐ No ☐ Pending
☐ Health Insurance Policy
Specify _____
☐ Medicaid/Medical Assistance
☐ Medicare

Veteran Status

Are you a Veteran?
☐ yes ☐ no

Assistance

Check any of the following that have provided assistance to you during the past year:

☐ Area Agency on Aging
☐ Hotline for Disability Services
☐ Independent Living Center
☐ Nebraska Assistive Technology Partnership
☐ Nebraska Commission for the Blind and Visually Impaired
☐ Nebraska Commission for the Deaf and Hard of Hearing
☐ Nebraska Health and Human Services
  ☐ Aid to Aged, Blind, and Disabled
  ☐ Developmental Disabilities
  ☐ Disabled Person and Family Support
  ☐ Medicaid Waiver
  ☐ Medically Handicapped Children Program
  ☐ Social Services Block Grant
☐ United Cerebral Palsy of Nebraska
☐ Nebraska VR (Vocational Rehabilitation)
☐ Other _____

Expenses Related to Disability (e.g., medication, doctor bills, transportation special equipment)	Amount

Household members

Name	Relationship	Date of birth	State ward	Disabled

Financial Information

List the amount of income you receive from each of the sources below. Single adults (19 years of age or older with no minor children) should list only your income. Families should list income of married couples or income of all adults, including wages of children ages 14-18.

Gross Income (before deductions)	Amount	How often received	Who receives it
Wages, overtime, bonuses, commissions, etc			
Self-employment (use current IRS 1040)			
Interest dividends, money from investments and capitol gains			
Social Security Disability			
Social Security Income (SSI)			
Social Security Retirement			
Veteran's Benefits			
Pensions			
Retirement, Keogh Accounts, IRA's, etc.			
Inheritance, estates, trust funds, etc			
Aid to Aged,Blind, and Disabled (State Supplemental Check)			
Temporary Need for Need Families (TANF)			
Alimony/Child Support			
Compensation (workers and unemployment)			
Rental Income			
Other (insurance settlements, lottery winnings) Please describe			

Assets

List all assets (e.g., cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, farmland, etc.)

Type	Amount

Release/Agreement Form

I verify that the information provided on this application is correct and complete.

I understand that whenever changes occur in the information provided, I need to report them immediately to the agency/agencies helping me with this request.

I understand I have the right to appeal if I am not satisfied with an agency's action.

I understand that this is a **multi-agency form**. The agencies/programs listed below may contact each other to determine my financial eligibility for their programs, and may verify my need of the support for which I have applied. I authorize the release of this information to be used for referrals/services for which it is determined I may be eligible. It is my understanding that this information will be held confidential by all the agencies listed.

- Client Assistance Program
- Hotline for Disability Services
- Independent Living Centers
- Muscular Dystrophy Association
- Disability Rights Nebraska
- Nebraska Assistive Technology Partnership
- Nebraska Assistive Technology Partnership-Education
- Nebraska ChildFind
- Nebraska Commission for the Blind and Visually Impaired
- Nebraska Commission for the Deaf and Hard of Hearing
- League of Human Dignity
- Nebraska Department of Health and Human Services
- Easter Seals Nebraska
- Nebraska Department of Veterans' Affairs, Nebraska Veterans' Aid Fund
- Nebraska Housing Developers Association and Home Owners Program
- Paralyzed Veterans of America Education Center
- Rebuilding Together
- Temporary Assistance for Needy Families (TANF)
- The Arc of Nebraska
- United Cerebral Palsy of Nebraska
- US Department of Agriculture (USDA)
- Nebraska VR
- Other _____

Information may be released and shared on my behalf with the following family members and individuals:

_____

_____

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Signature of applicant (or guardian) **Date**

Application and release is valid for **one year** duration from date of signature

Ethnicity/race (please check)

The following information is being requested for Federal reporting purposes only. Your response is optional and will not affect your eligibility determination. We would appreciate your assistance by providing a response.

☐ White (non-hispanic) ☐ Black (non hispanic) ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander
☐ Hispanic ☐ Multi-Racial ☐ Other _____

Return this form to:

UCP of Nebraska
920 S. 107th Avenue, Suite 302
Omaha, NE 68114
Fax 402-502-6791
Email: annebrodin@ucpnebraska.org

Please answer the following questions as they relate to the request.

If the cost of the request(s) exceeds the $1,000 maximum allotment, what additional funding is in place to secure the request?

How will the request increase the individual's independence and quality of life?

Additional comments:

UCP United Cerebral Palsy of Nebraska

Life without limits for people with disabilities

UCP of Nebraska is committed to "advancing the independence, productivity and full citizenship of people with disabilities through an affiliate network."