B. Thomas Golisano Life Enhancement Fund
Future Care Community Third Party Pooled Trust Application

For Office Use Only

Received Date: _____ Approved Date: _____

Approved Amount: $_____ Approved Excess Amount: $_____

Rejected: _____ Note: _____

****To avoid application being returned or delays, please answer all questions****

FBO: Client/ Beneficiary full first and last name: _____Date: _____

1. AGENCY INFORMATION: (Please print)

Agency: _____ Tax ID#_____

Address: _____ City: _____

Zip Code: _____ County: _____ Phone #: _____

Email: _____

Submitted By: (Print Name and Title) _____

ATTACH ONLY THE REQUIRED DOCUMENTS AS DESCRIBED BELOW

2. REQUIRED DOCUMENTS

Proof of Disability: Proof a disability determination has been made by the Social Security Administration of the New York State Department of Human Services is required. Only the documents described below will be accepted. check which document is attached:

☐ **Social Security Disability Determination**: SSI/SSD award letter, a disability benefit verification letter or other letter from the Social Security Administration stating the benefit received is because the individual is disabled.

☐ **NYS Department of Human Services (DHS) MEDICIAD Disability Determination**; (OHIP-0040, OHIP-00405, DSS-4141, or Idss-4141 OR Disability review Team Certificate (DSS-630, or LDSS-630)

Please note the following documents are NOT acceptable:

1. Social Security Income or Notice of Decision Letters
2. OPWDD Eligibility Letters

3. BENEFICIARY INFORMAITON:

Name: _____ D.O.B: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

County: _____ Phone # _____ SS# _____

Disability Type:

Autism ☐ Intellectual/ Developmental ☐ Physical ☐ Cerebral Palsy ☐ Mental Health ☐

Traumatic Brain Injury (TBI) ☐ Epilepsy ☐ Neurological Impairment ☐ Other:

Does Beneficiary have a Supplemental Needs Trust? ☐ Yes ☐ NO if yes, please provide the Trust information and explain why it is not being used for this request. _____

Does Beneficiary receive SSI? Yes ☐ No ☐

What other funding sources have been explored prior to applying to this fund and what was the outcome? Please list funding source and outcome below:

Funding Source	Outcome

4. REQUEST INFORMATION: List the item (s) or Service (s) being requested

Note: Protection Plans and warranties are not covered through this fund. If the request is for an electronic device, please include an explanation as to how the device is connected to the beneficiary's disability and how it is intended to enhance the beneficiary's quality of life.

List Requested Item (s) in this section	List the Price or Cost of Each Requested Item in this section

Briefly describe how the requested items/ services will enhance the Beneficiary's life: (4 sentences or less)

Proof of Purchase Price: Check which document is attached to the application.

Invoice/ Quote: ☐ training receipt: ☐ online printout: ☐ Other: ☐

PRICE $ _____Est. TAX $ _____S&H if applicable: $ Total Cost: $ _____ Total Amount Requested $_____

Note: If the total cost exceeds the $500.00 funding cap., please explain how the remainder will be paid.

ADDITIONAL BENEFICIARY INFORMATION: (Optional)

Date of Birth: Month _____ Day _____ Year _____

Gender: Male ☐ Female: ☐ Transgender ☐

Ethnicity: _____

Name of Caregiver: _____ Relationship: _____

DECLARATIONS

- The Beneficiary is age 18 or older.
- The Beneficiary has a qualifying disability
- The Beneficiary lives in the Greater Rochester/Finger Lakes Region.
- The Beneficiary does not live in a certified residential setting.
- The Beneficiary has not received a grant from the fund this calendar year.

I have included all required documents and I verify the information entered on this application is accurate. *I HAVE REVIEWED THIS APPLICATION. I VERIFY THE BENEFICAIRY HAS A QUALIFYING DISABILITY AND I HAVE INCLUDED ALL NECESSARY DOCUMENTATION. THE BENEFICIARY LIVES IN THE GREATER ROCHESTER/FINGER LAKES REGION. THE BENEFICIARY HAS NOT RECEIVED A GRANT FROM THE FUND IN THIS CALENDAR YEAR. I UNDERSTAND THE AWARD MAY BE SUBJECT TO TAX AND IF THE REQUEST IS APPROVED, THE BENEFICIARY WILL RECEIVE A K-1 STATEMENT BY APRIL 15.

Community Professional Signature: _____ Date: _____

Print or Type Name and Title: _____

Beneficiary: I understand I must have a qualifying disability and the requested item/ service must be for my **SOLE** benefit. I understand this gift may be taxable and I will receive a K1 statement from Future Care Planning Services prior to April next year for tax purposes. I consent to this application being submitted on my behalf.

Beneficiary Signature if able to sign: _____ Date: _____

If other than beneficiary, please check the appropriate relationship: Parent ☐ Guardian ☐ Advocate ☐

Location where reimbursement should be mailed if different from Agency Information listed

Agency: _____ Attention: _____
Address: _____ City: _____ Zip Code: _____

Please return this application to:

B. Thomas Golisano Life Enhancement Fund
Future Care Community Pooled Trust
1000 Elmwood Avenue, Suite 500
Rochester, New York 14620-3098

Or email to: golisanofund@futurecareplanning.org or Fax: 585-210-4048