SHARED HORIZONS
ENHANCING LIVES, PROTECTING FUTURES

4301 Connecticut Avenue, NW, Suite 140 ◆ Washington, D.C. 20008
Telephone 202-448-1460 ◆ Fax 202-448-1461
Email: info@shared-horizons.org ◆ www.shared-horizons.org

Shared Horizons' Charitable Fund Application

The Shared Horizons' Board of Directors launched the Charitable Fund at our sixth Annual Dinner Dance of Thanksgiving in November 2014. The Fund was created to enhance the lives of people with disabilities through the purchase of goods and services not covered by public benefits.

If you are, or know of a person with a disability, who lives in the District of Columbia, Maryland or Virginia, and can demonstrate financial need, we encourage you to submit an application.

The Charitable Fund Committee will accept and review applications on a rolling basis, but will only review and approve applications 3 times per year. Contact our office using the information below to learn more about Shared Horizons' Charitable Fund.

NOTE: *We are not approving "end of life planning" requests at this time. We may revisit as the fund grows. Stay tuned for updates!*

QUICK Q&A

- **Who is eligible for the Shared Horizons' Charitable Fund program?** In order to be eligible for this program, a recipient must have a disability, meet the criteria for demonstrating financial need, receive a means-tested benefit, and reside in the D.C., Maryland, and VA.

- **Who can submit the Shared Horizons' Charitable Fund application?** Charitable Fund applications must be completed, signed, and submitted by a representative from a nonprofit organization, public agency, court-appointed Guardian or conservator on behalf of the applicant. Any applications that do not meet this criterion will be returned to the sender or denied.

- **Where can I obtain an application for Shared Horizons' Charitable Fund?** Contact Shared Horizons at 202-448-1460 for an application packet. Applications are accepted on a rolling basis; however, the awards are decided in March, June and October by the Charitable Fund Committee. These dates may be adjusted without notice. If this happens, the committee will make every effort to notify applicants about those changes.

- **How detailed does the request need to be?** Please complete all questions on the application. Supply enough information about the recipient's disability and the requested item or service so that the committee can evaluate how the equipment, medication, or service requested will impact the life of the recipient. If additional space is needed for any response, use the supplemental information page or attach an additional page.

- **What is the maximum amount that can be requested?**
  The maximum amount per Award is $1,000; however, please only apply for what is needed. If the Recipient would benefit from an item costing $500, do not request more simply because you can. This program has a limited amount of funds available and we hope to fund as many applicants as possible by ensuring that requests are reasonable. Please request one item or service per application.

- **Can the cost of the requested item/service be more than $1,000?**
  If the amount required for the equipment/medication/service is over $1,000, the maximum amount that can be requested through this program is $1,000. Please apply for the full $1,000 and include documentation to show the source of additional funding that is needed in order to complete the project or purchase the item.

- **Why is a price quote/estimate required?**
  The committee evaluating applications would like documentation confirming the anticipated cost of the item or service in order to properly evaluate the request. A direct quote is preferred, but an estimation showing how the amount being requested was derived will be adequate.

- **How does the vendor get paid?**
  If an application is funded, the award will be made in the form of a check made payable to the vendor listed on the application. Please be sure that the vendor will accept checks. Award checks will be mailed to the representative who completed the application, not directly to the Recipient or the vendor.

  Will you just issue a check payable to the Recipient?
  We will **NOT** issue a check payable directly to the Recipient. Many Recipients receive SSI/Medicaid benefits and receiving cash in this way would jeopardize those benefits. Also, issuing the check payable to a vendor helps to ensure that the funds will be used for their intended purpose.

- **Why is the vendor's address required?**
  We ask for the vendor's address for informational purposes only – we may have follow-up questions about their services. We will not mail checks to the vendor unless special arrangement have been made.

- **When will I find out if the request has been funded?**
  Notifications will be mailed within 14 business days of the award decision. All submissions, approved and not approved, will receive a notification from the Charitable Fund. Applicants not approved can resubmit their application in the next round.

- **How many requests will be funded?**
  A limited amount of funding is available for this program each year, and each year has been increasingly competitive. Applications are evaluated and funded based on need and available funds.

- **What types of items/services will be considered?**
  Shared Horizons Charitable Fund will consider goods and services that enhance the lives of people with disabilities, as long as the request does not supplant the applicant's means-tested public benefits and it meets the "sole benefit" test.
  The Charitable Fund will not consider requests for illegal or potentially harmful activities. The committee has full discretion when approving or denying applications.

APPLICATION
REMIT (pages 3 and 4) of the APPLICATION AND SUPPORTING DOCUMENTATION TO:
Shared Horizons, Inc. Charitable Fund
4301 Connecticut Avenue, NW, STE 140, Washington, D.C. 20008
For questions call 202-448-1460 or Email Events@shared-horizons.org

REPRESENTATIVE'S INFORMATION

Name: _____

Organization: _____ Title: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

APPLICANT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: ____ Current Benefits: ☐SSI ☐Medicaid ☐Other

Provider Agency: _____

Service Provider: _____

Please specify the characteristics of the special need or explain the applicant's disability:

_____
_____
_____

Please list the request and provide details about why the request is being made. See *"Supplemental Information Form (page 4)"attached if requesting services related to "therapeutic activities and treatments*:

_____
_____
_____
_____
_____

Attachments:

☐INVOICE ☐ESTIMATE☐MEDICAL DOCUMENTATION☐MEDICAID/INSURANCE DENIAL
☐SUPPLEMENTAL SECURITY INCOME DETERMINATION LETTER

SUPPLEMENTAL INFORMATION FORM

Complete this form if you need to provide more detail about your request or if you are requesting services related to therapeutic activities or treatments.

How will the therapeutic activity or treatment be sustained (financially) in the future? _____

_____

What is/are the short-term benefit(s) of the therapeutic activity or treatment? _____

_____

_____

For (classes or sports), is there a long-term scholarship available through another agency or organization?

❑YES ❑NO

List any other agencies or organizations from which you have received or are seeking funding: _____

_____

_____

Please use the space below for any additional information you may wish to include**:** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____