Committee of Last Resort is now Helping Hands!

Helping Hands (HH) Application

This form should be completed in its entirety.
Incomplete forms will be returned to submitter and may delay a decision.

SECTION 1

Date of Request:

Applicant Name: _____ Phone Number: ____- ____- _____
Street Address: _____

Submitter Name (if different from applicant): _____
Relationship to Applicant (i.e. Care Coordinator (CC), parent, etc):_____
Phone Number (if different from applicant): ____- ____- _____
Email Address: _____@_____

Care Coordinator Supervisor (if submitter is CC):_____
Phone Number: ____- ____- _____ Email: _____@_____

Has the applicant been deemed eligible for services with the Office for People with Developmental Disabilities (OPWDD) ☐ Y ☐ N *Copy of eligibility letter MUST BE included with application.

Does the applicant have an OPWDD Self-Direction Budget? ☐ Y ☐ N If yes, please explain why this request cannot be covered by their budget: _____
_____

SECTION 2-

☐ **Please check here if this is an emergency request and provide detailed explanation of circumstances** (please see below or see program guidelines for "emergency" situations that will be considered)**:**

_____
_____
_____
_____

☐ **Please check here if this is a supplemental "scholarship" request** (all requests that don't fit "emergency" criteria)

***Emergencies that will be considered by the committee are those that put an individual's immediate health and safety at risk.** Marking application as emergency does not guarantee emergency priority. More documentation may be requested by the committee.
***Non-emergency (supplemental) requests** will now include all requests for respite reimbursement, recreational activities, equipment, or any other requests that do not fit emergency criteria.

SECTION 3- (Required for both emergency and supplemental requests)

Amount being requested: $_____ Please provide as many specific details about this request as possible, including: total cost of item, service or total bill, severity of need, how this item will benefit the applicant:

_____
_____
_____
_____
_____
_____

What specific efforts have been made to meet this request, and by whom? (Refer to program guidelines for suggested resources. Please note that Helping Hands must be the funding source of LAST RESORT therefore if suggested/available resources have not been exhausted, request may be denied until other sources are attempted). Please attach denial(s), invoice/estimate/bill, or any other documentation detailing attempts made to secure funding): _____

_____
_____
_____
_____

If Family Reimbursement funds have been exhausted for the year, please describe what the funds were used for (*letter or email correspondence documenting attempt to secure FRP funds must be included*):

_____
_____
_____

Please explain what the applicant/family's plan is moving forward to address this need. _____

_____
_____

SECTION 4- (Required for both emergency and supplemental requests)

Please provide the following details regarding household finances: How many people live in the household? _____
Household income(s): $_____ which includes (i.e. wages, SSD/SSI, child support, etc.) _____

_____

What recurring bills/debts does the applicant/family pay:
Rent/mortgage $_____ Insurance $_____ Car payment $_____ Student Loan(s) $_____
Utilities $_____ which include _____
Other recurring debts/bills: $_____ including _____

_____

Please provide any other details important for the committee to know regarding the applicant/family's circumstances that contribute to hardship: _____

_____
_____
_____
_____

Has this person received funding from the Committee of Last Resort/Helping Hands in the last twelve months?
Yes ☐ No ☐
If so, when and for what _____

*By Signing OR typing name below, I take full responsibility for the authenticity and accuracy of the information provided in this application:

Submitter Signature _____ Date

All Helping Hands applications (with all additional documentation) should be emailed *IN A HIPAA COMPLIANT MANNER* to: helpinghands@aspirewny.org

If email is not accessible to submitter, application can be:

- **FAXED TO (716) 831-1145 with subject, "ATTN: Helping Hands Committee"**
- **SENT VIA POSTAL MAIL to: ATTN- Helping Hands Committee/Agency Outreach & Central Intake 7 Community Dr., Cheektowaga NY 14225 OR 140 Mall Blvd., Lakewood NY 14750**

***In addition, all questions regarding any aspect of the Helping Hands program should be addressed to helpinghands@aspirewny.org**

FOR COMMITTEE USE ONLY:

☐ **Emergency Request (HH Coordinators- please attach email correspondence from committee approval)**
☐ **APPROVED DATE APPROVED: AMOUNT APPROVED: $_____**
Explanation of approval (including vendor/individual to be paid): _____
_____
_____

☐ **NOT APPROVED**
☐ **ADDITIONAL RESOURCES AVAILABLE: _____**

☐ **OTHER, PLEASE EXPLAIN: _____**
_____

☐ **Scholarship Request (HH Coordinators- please attach committee meeting minutes)**

Date of Award Meeting:
Was this request awarded scholarship? ☐ Yes ☐ No If yes, amount awarded $_____
Vendor/individual to be paid (include name and address): _____
_____

HH Coordinator Signature: _____ Date: