



# HEIGHTENED INDEPENDENCE & PROGRESS

A CENTER FOR INDEPENDENT LIVING FOR PEOPLE WITH DISABILITIES

## COVID-19 Community Response Program Funding Application

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Veteran: Yes  or No   
 Check  all that apply:  Disability (specific) \_\_\_\_\_  Senior  
 How many people live in this home? \_\_\_\_\_ Do you own your property? Yes  or No   
 What are you requesting and the reason why (COVID-19 Related)?  
 \_\_\_\_\_  
 \_\_\_\_\_

If someone other than the homeowner/renter prepares this application, or helps the homeowner/renter fill it out, please complete the following:

Name of Preparer: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Race and Ethnicity Data (optional)

Race and ethnicity information provided by the applicant for services from Heightened Independence and Progress (**hip**) is used for reporting purposes only. Providing this information is optional. Our compiling of such data is expected to benefit the delivery of affiliated services. Information provided (or waiving the option to report this information) will have absolutely no influence on your eligibility for services provided by **hip**.

Check all categories that apply.

Hispanic	White	Asian	Black or African American	Native American or Alaska Native	Native Hawaiian or Other Pacific Island	Other: Please Specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Financial Information**

Please provide financial information below:

Income Sources	Your income (monthly)	Total household income (Annually)
Employment	\$	\$
Social Security	\$	\$
SSI	\$	\$
Pension	\$	\$
Retirement	\$	\$
VA	\$	\$
Rental	\$	\$
<b>Total monthly income:</b>	\$	\$

**Do you have any disability-related expenses? How much and please explain?**

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**Please review and sign before submitting.**

I, \_\_\_\_\_, certify that the information provided on this application is accurate and complete.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please submit the 3-part application and the required documents mentioned on the cover letter.**

**Mail to:      Heightened Independence and Progress (*hip*)  
                  Attn: COVID-19 Response Program  
                  131 Main Street, Suite 120  
                  Hackensack, NJ 07601**

**You may also fax to: 201-996-9422 Attn: Maria Valentin or Email at: [mvalentin@hipcil.org](mailto:mvalentin@hipcil.org)**

**Incomplete applications will not be processed.**

Independent Living Plan

Centers for Independent Living are required to have all consumers either complete and sign an Independent Living Plan on Section 1 **or** sign a statement that they prefer to waive that option on Section 2 but **not both**. *hip* will provide all services to consumers regardless of their choice.

**Section 1:** Goal: To achieve optimal independence and safety at my home.

Plan: Make services available to me through *hip*'s COVID-19 Community Response Program by submitting all required documents.

Projected Date of Completion: ASAP

I was responsible for developing my own plan, and I understand that I may change my plan at any time.

Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_

Date: \_\_\_\_\_


OR

**Section 2:** Waiver

In signing this Independent Living Plan Waiver, I have chosen not to establish goals in writing. I have been informed and understand that I will receive all necessary services from *hip* regardless of this decision. I further understand that I have the right, at any time I choose, to develop an Independent Living Plan.

Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

 If I am dissatisfied with the services provided to me by Heightened Independence and Progress (*hip*), I can contact the Client Assistance Program (CAP) at 1-800-922-7233 or 609-292-9742 Voice/TDD. The New Jersey Client Assistance Program (CAP) is a federally funded program which advocates for and protects the rights of individuals with disabilities who are seeking or receiving rehabilitation services.

**Office use only:**

*hip* Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_