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
☐	☐	☐	☐	☐	☐	☐

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Financial Information

Please provide financial information below:

Income Sources	**Your income (monthly)**	**Total household income (Annually)**
Employment	$	$
Social Security	$	$
SSI	$	$
Pension	$	$
Retirement	$	$
VA	$	$
Rental	$	$
Total monthly income:	$	$

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

____

____

____

****

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

Incomplete applications will not be processed.

hip HEIGHTENED INDEPENDENCE & PROGRESS

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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: ____ Date: _______________

Print Name: ____

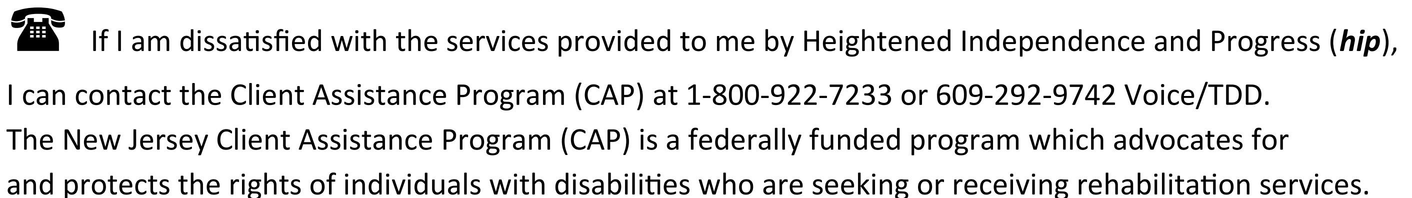
OR

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: ____ Date: _______________

Print Name: ____



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: _________________________________