

## Modification Access Project (MAP)

This is a partial funding program and most requests do not exceed \$2000

### Homeowner/Renter's Name & Address

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? \_\_\_\_\_

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"/>

Please check  off one:

The above information has been freely and accurately reported to the best of my knowledge.

**OR**

I choose to exercise my option not to report the requested information.

**Financial Information**

**hipcil** uses the following low-income guidelines set by the Bergen County Department of Human Services:

Your income for 2025 (100%-200% Federal Poverty Level) Single (\$1,304-\$2,608) Married (\$1,763 - \$3,525). Above income, may submit a letter with disability-related expenses and **hipcil** will take it into consideration for funding assistance.

Please provide financial information below:

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

**Please submit copy of the following document(s) when you return the 3-page completed application. Applications submitted without these document(s) will not be considered, as well as an incomplete application.**

Proof of income (submit one only) for all residents in your home:

- a copy of your (and/or their) W2 or benefit/retirement statement(s)
- OR a copy of your (and/or their) last year's Federal tax return (1040)
- Or a copy of your (and/or their) SSI Statement
- Doctor's letter stating your disability and the modification you need done at your current home.
- Copy of you identification
- Two (2) written estimates from different vendors detailing the home modification and cost of project.
- **\*\*\*Renters** are required to provide written permission from the owner of the property and send along with this application.

**Please review and sign before submitting.**

**Mail to:           Heightened Independence and Progress (hip)  
                           Attn: MAP Program  
                           190 Moore St. Suite 101, Hackensack, NJ 07601**

Centers for Independent Living are required to have all consumers either complete an Independent Living Plan (Section 1) or sign a statement that they prefer to waive that option (Section 2). *hip* will provide all services to consumers regardless of their choice.

Consumer Name: \_\_\_\_\_

Please complete and sign either Section 1 or Section 2—**not both**.

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**INDEPENDENT LIVING PLAN (Section 1)**

Main Goal: To achieve optimal independence by enhancing my daily living skills.

Projected Date of Completion: As soon as possible.

Activities to Help You Reach This Goal:

1. Activity: Obtain required application documentation for funding.

Projected Date of Completion: ASAP

2. Activity: \_\_\_\_\_

Projected Date of Completion: \_\_\_\_\_

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

Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**INDEPENDENT LIVING PLAN WAIVER (Section 2)**

Please sign below if you have decided not to do a written Independent Living Plan at this time.

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.

Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If I am dissatisfied with the services provided to me by Heightened Independence and Progress, I can contact the Client Assistance Program (CAP) at 1-800-922-7233 or 609-292-9742 Voice/TDD.**