HEIGHTENED INDEPENDENCE & PROGRESS

A CENTER FOR INDEPENDENT LIVING FOR PEOPLE WITH DISABILITIES

Modification Access Project (MAP)

This is a partial funding program and most requests do not exceed $1800

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
☐	☐	☐	☐	☐	☐	☐

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.

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Financial Information

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

Your income for 2019 is less than $27,951 if single or less than $34,268 if married. Above income, may submit a letter with disability-related expenses and hip with take it into consideration for funding assistance.

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:	$	$

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.
- Two (2) written estimated 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
131 Main Street, Suite 120
Hackensack, NJ 07601

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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 if you prefer to waive that option on Section 2 but **not both**.
hip will provide all services to consumers regardless of their choice. **Application will not be accepted if this page is not signed, which will delay your funding request.**

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

Plan: Make services available to me through ***hip***'s Modification Access Project funding 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: _____

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: _____

☎ 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: _____