HEIGHTENED INDEPENDENCE & PROGRESS

A CENTER FOR INDEPENDENT LIVING FOR PEOPLE WITH DISABILITIES

2024 SAIL APPLICATION

Welcome to the (SAIL) Program Administered by Heightened Independence and Progress, a Center for Independent Living (hipcil).

In order for us to be more efficient in evaluating your request for funding

We will not be able to process your request, until all documents are received.

Consumer 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 ☐

Amount of monthly rent/mortgage_____

What item are you requesting?

_____

Please describe how this item may assist you?

_____

_____

***Air conditioners may only be funded for individuals with chronic heat related health risks.**

Window Unit _____ Wall/Sleeve Unit _____ Dimensions_____

***A one-time annual $500.00 SAIL funding towards the purchase of incontinent, wound care supplies, for individuals in need.**

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.

Latino	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 Department of Human Services:

Your income for 2023 (100%-200% Federal Poverty Level) Single ($1,133-$2,265) Married ($1,526- $3,052). Above income, may submit a letter with disability-related expenses and hip with take it into consideration for funding assistance.

Please provide the financial information below: Submit proof of income.

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

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

Additional documents needed to be submitted with this application:

- Doctor's letter/prescription stating your disability and the item you need to accommodate your disability.
- Proof of income, copy of identification and insurance.

Please review and sign before submitting.

Mail to: **Heightened Independence and Progress (*hip*)**
Attn: SAIL Program/Alejandro Paredes
35 Journal Square, Suite 912
Jersey City, New Jersey 07306

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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 the Special Assistance for Independent Living (SAIL) 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: _____