

2026 SAIL APPLICATION

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

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
<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.

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 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


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: _____