hip HEIGHTENED
INDEPENDENCE & PROGRESS
A CENTER FOR INDEPENDENT LIVING FOR PEOPLE WITH DISABILITIES

Special Needs Assistance Program (SNAP)

This is a partial funding program and most requests do not exceed $300

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 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 stating your disability and the item you need to accommodate your disability.
- Proof of income, residency and copy of identification.
- One written estimate from a vendor detailing the cost of the item.

Please review and sign before submitting.

Mail to: **Heightened Independence and Progress (*hip*)**
Attn: SNAP 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 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 Special Needs Assistance Program (SNAP) 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: _____