Uniting Families
Protecting Dreams
Defending Futures
Since 2014

●www.SonsAndDaughtersUnited.org
● 269-716-8090
● 1129 N. Washington Ave. Lansing, MI 48906

Renee Wolfe Memorial Grant Application

Inspired by the compassion of longtime activist, Renee Emery Wolfe, The Renee Emery Wolfe Memorial Grant is awarded to people with disabilities who are facing financial struggles, housing difficulties, or trouble securing food. The program is primarily managed by the Organization's Disability Advisor in conjunction with CLUMP.

In order to be considered for The Renee Emery Wolfe Memorial Grant the applicant must meet the following criteria:

➔ Be able to demonstrate clear financial need

➔ Have a debilitating physical or mental Disability

Items covered under the The Renee Emery Wolfe Memorial Grant are as follows:

● Non-perishable food items
● Gift cards to local food markets, grocery stores, and supermarkets
● Gas cards
● Utility bill assistance
● Rental/mortgage payment assistance
● Transportation assistance
● Medical/mobility equipment
● Medication assistance/Medical services.
● Clothing

THE FOLLOWING DOCUMENTS ARE REQUIRED FOR THE RENEE WOLFE GRANT:

In addition to the application itself, Applicants are required to disclose pay stubs, bank account statements, and any other financial documents to demonstrate financial need. Applicants will typically receive approval or denial in writing within 30 business days

APPLICANTS MUST PROVIDE THE FOLLOWING DOCUMENTS IN HARD COPY FORMAT:

-PHOTO COPY OF STATE ID (MUST BE A CLEAR COPY OF FRONT AND BACK)
-SIGNED RELEASE OF INFORMATION (THIS FORM IS CONTAINED WITHIN THIS PACKET)
-PROOF OF FINANCIAL ASSISTANCE
-RECENT BANK STATEMENT/PAYSTUBS/TAX DOCUMENTS
-RECENT MEDICAL DOCUMENTS/ PROOF OF DISABILITY

Additional Supporting Documents
Provide these items if the following statements apply to you.

Income Statement(s:) if you are employed; provide recent paystubs showing employer name(s) and year to date income

Benefit Statement(s): if you receive benefit income, such as unemployment, social security, or other government benefits; provide statement(s) showing the benefit amount and payee name

Federal Tax Return: if you are self-employed; provide a copy of your federal tax return to document your self-employment income.

BASIC INFORMATION:

Please clearly print the following information in blue or black ball point pen:

Full Legal Name

Last Name:_____
First Name:_____
Middle Name: _____
Suffix:_____

Date of Birth (month/day/year)_____/_____/_____
Social Security Number:_____-_____-_____

Contact Information

Home Phone: _____Cell Phone:_____
Email Address:_____

Permanent Residence

Number, Street and Apartment Number_____
City_____State_____ZIP_____County_____
Mailing Address (if different than permanent address)
Number, Street and Apartment Number_____
City_____State_____ZIP_____County_____

I am a…..(check one)

- ❑ U.S. citizen
- ❑ U.S. national
- ❑ Resident alien expecting citizenship

DISABILITY INFORMATION:

Diagnosis and brief medical history (please provide estimated dates of medical diagnosis):_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HOUSEHOLD INFORMATION:

How many persons live in your household?_____
How many persons are under the age of 18?_____
How many Persons living in your household are your dependents?_____
Marital Status (i.e single, married, divorced, widowed)_____

Please list any members of your household who are currently receiving any income ,financial assistance or benefits. Additional documents may be required.

Last Name:_____
First Name:_____
Middle Name: _____
Date of Birth (month/day/year)_____/_____/_____
Income Source_____
Gross amount of income _____
How often is the income received_____
How is this person related to you?_____
Other income information:
_____
_____

First Name:_____
Middle Name: _____
Date of Birth (month/day/year)_____/_____/_____
Income Source_____
Gross amount of income _____
How often is the income received_____
How is this person related to you?_____
Other income information:
_____
_____

First Name:_____
Middle Name: _____
Date of Birth (month/day/year)_____/_____/_____
Income Source_____
Gross amount of income _____
How often is the income received_____
How is this person related to you?_____
Other income information:
_____
_____

First Name:_____
Middle Name: _____
Date of Birth (month/day/year)_____/_____/_____
Income Source_____
Gross amount of income _____
How often is the income received_____
How is this person related to you?_____
Other income information_____

First Name:_____
Middle Name: _____
Date of Birth (month/day/year)_____/_____/_____
Income Source_____
Gross amount of income _____
How often is the income received_____
How is this person related to you?_____
Other income information:
_____
_____

Do you need help applying for help through the state? ___yes___no

What kind of assistance do you require? (Please check all that apply)

- ❑ Financial Assistance
- ❑ Housing Assistance
- ❑ Food Assistance
- ❑ Other

If you chose other, please explain:_____
_____

Housing status:
Rent __
Own __
Homeless___
Other_____

Are you currently living in subsidised housing or receiving government assistance?_____
If so what type of benefits are you receiving?_____

How long have you held occupancy in this residence?_____

Monthly rent, house payment, mortgage payment_____

Estimated cost of Utilities in total:_____

Additional housing expenses: _____

By applying for this grant I hope to receive (check all that apply):

□--Non-perishable food items___
□--Gift cards to local food markets,
□ --Grocery stores, and supermarkets___
□--Gas cards__
□--Utility bill assistance___
□--Rental/mortgage payment assistance___
□--Transportation assistance___
□--Medical/mobility equipment___
□--Assistance with medical bills or prescription costs ___
□--Clothing/household staples assistance___
□--Other___

Is there any additional information you would like to provide not covered in this application?(you may also provide additional documentation of need with this
packet):_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did you receive word of this grant?:

_____

Did anyone refer you to Sons and Daughters united for assistance?:

_____

Have you received assistance (financial or other) from Sons and Daughters United in the past?
□ Yes. □ No

Please return by email to: missy@sonsanddaughtersunited.org
Or by mail to:
Sons and Daughters United
P.O. Box 154
Niles, MI 49120

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

I,_____, have read and understand the conditions of the Code of Ethics provided to me by Sons and Daughters United. I understand that application for this grant does not automatically qualify me for assistance. I understand that incorrectly or fasly providing information may result in disqualification for this grant. Lastly, I affirm that all information provided herein was provided willingly and is true and accurate to the best of my belief and knowledge.

Date:_____
Signature:_____
Printed name:_____

I,_____, authorize Sons and Daughters United to confirm and/or obtain any and all information provided within this application (including but not limited to: income information , prior employment history, disability information, and/or medical records). I understand that additional documentation may be required.

Print name _____

Signed name _____

Date_____