DISABILITY SERVICES COMMITTEE
ROTARY CLUB OF SPOKANE #21
PO Box 90
SPOKANE, WA 992

INSTRUCTION FOR DISABILITY APPLICATION FORM

The Disabilities Committee of Rotary Club of Spokane #21 meets the third Monday of every month to review applications and make recommendations on funding Disability Accommodations to the Rotary Club's Board of Directors. Our mission is to "Assist individuals in financial need living with disabilities to improve their health and independence by obtaining medical and adaptive resources." To expedite your application process, please ensure DOCUMENTATION IS INCLUDED. Incomplete forms will be returned to the applicant without processing. Additional application forms may be requested from the Disabilities Committee at the following address:

DISABILITY SERVICES COMMITTEE
ROTARY CLUB OF SPOKANE #21
PO Box 0
Spokane, WA 992

Or email to:
executivedirector@rotaryspokane.com

- Make sure signature of person authorized to release confidential information is attached.
- Attach picture if requesting medical equipment, with specifications and costs included.
- Attach letter of history and justification for desired equipment from Primary Care Physician or other appropriate specialist.

Send completed application forms (3 pages) to:

DISABILITY SERVICES COMMITTEE
ROTARY CLUB OF SPOKANE #21
PO Box 1117
Spokane, WA 99210

Or email to:
executivedirector@rotaryspokane.com

DISABILITIES COMMITTEE
ROTARY CLUB OF SPOKANE #21
PO Box 9046
SPOKANE, WA 99209

DISABILITY APPLICATION FORM

FOR COMMITTEE USE ONLY
DATE RECEIVED _____

MEMBER ASSIGNED _____
(CIRCLE ONE) APPROVED / DENIED
DATE RECOMMENDED _____

Part A – Applicant Identification and Insurance Information

NAME	AGE	DATE OF BIRTH (MM/DD/YYYY)		TELEPHONE NO. (DAYTIME)
STREET ADDRESS	CITY		STATE	ZIP CODE
IF THE APPLICANT IS A CHILD (UNDER THE AGE OF 18) OR A DEPENDANT, THE FOLLOWING INFORMATION IS REQUIRED FROM EITHER THE PARENT OR LEGAL GUARDIAN:				
NAME (OF INDIVIDUAL RESPONSIBLE FOR APPLICANTS CARE)	E-MAIL ADDRESS			TELEPHONE NO. (DAYTIME)
STREET ADDRESS	CITY		STATE	ZIP CODE
INSURANCE INFORMATION:				
MEDICARE ☐ MEDICAID ☐ OTHER: ☐	APPLICANT'S INSURANCE I.D. NUMBER:			
APPLICANT'S INSURANCE POLICY GROUP NUMBER	APPLICANT'S INSURANCE PLAN NAME OR PROGRAM NAME			

Part B – Referral Information

BY WHOM WAS THE APPLICANT REFERRED?

Part C – History

DESCRIBE THE NATURE OF THE DISABILITY:	
NAME OF TREATING PHYSICIAN OR OTHER SOURCE	TREATING SOURCE'S TELEPHONE NO.

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HOW DOES YOUR DISABILITY AFFECT YOUR DAILY LIVING?

Part D – Accommodation Request

PROVIDE A DETAILED DESCRIPTION OF THE REQUEST. PROVIDE A TOTAL COST FOR THIS ACCOMODATION (INCLUDE ALL PROCESSING, SHIPPING AND HANDLING CHARGES AND ALL APPLIED TAXES). IF APPLICABLE, INCLUDE A QUOTE FROM THE LOCAL DISTRIBUTER OR RE-SELLER WITH NAME OF THE MANUFACTURER, MODEL #, AND VENDOR NAME AND CONTACT INFORMATION.	
TOTAL COST OF ACCOMODATION	$

Part E – Financial Request

LIST THE APPLICANT'S **HOUSEHOLD** MONTHLY INCOME AND EXPENSES.					
INCOME	AMOUNT	EXPENSE	AMOUNT		
WAGES & TIPS		RENT/MORTGAGE			
DISABILITY		INSURANCE			
RETIREMENT/ SOC. SECURITY		FOOD & TRANSPORTATION			
OTHER		OTHER			
TOTAL INCOME		**TOTAL EXPENSE**		REMAINING INCOME	

LIST **ALL OTHER** SOURCES THAT HAVE BEEN CONTACTED TO HELP FUND THIS REQUEST				
NAME OF FUNDING SOURCE	CONTACT NAME / TELEPHONE NO.	AMOUNT REQUESTED	AMOUNT APPROVED	IF DENIED, PLEASE EXPLAIN…

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TOTAL AMOUNT APPROVED BY OTHERS	

SUMMARY OF **ESTIMATED** FINANCIAL REQUEST (TO BE COMPLETED BY PREPARER)	AMOUNT	SUMMARY OF **ACTUAL** FINANCIAL REQUEST (TO BE COMPLETED BY DISABILITIES COMMITTEE)	AMOUNT
TOTAL COST OF ACCOMMODATION (PART D)		TOTAL COST OF ACCOMMODATION (PART D)	
REMAINING MONTHLY INCOME FOR APPLICANT		REMAINING MONTHLY INCOME FOR APPLICANT	
TOTAL AMOUNT FUNDED BY OTHERS		TOTAL AMOUNT FUNDED BY OTHERS	
AMOUNT REQUESTED		**AMOUNT FUNDED**	

Part F – Individual completing this form

NAME	PHONE NO. (DAYTIME)	PHONE NO. (EVENING)	E-MAIL ADDRESS	
STREET ADDRESS	CITY		STATE	ZIP CODE
WHAT IS YOUR RELATIONSHIP TO THE APPLICANT?		WHAT IS THE BEST TIME AND METHOD TO REACH YOU?		

Part G – Release of Information

I AUTHORIZE RELEASE OF THIS INFORMATION FOR THE USE AND PURPOSE OF THE ROTARY DISABILITIES COMMITTEE TO CONSIDER MY REQUEST FOR FUNDING. I UNDERSTAND THIS INFORMATION WILL BE SHARED WITH COMMITTEE MEMBERS AND OTHER ALLIED PROFESSIONALS, AS NEEDED, WHO MAY BE INVOLVED IN SUPPORTING THIS REQUEST. I FURTHER GRANT PERMISSION FOR ALLIED PROFESSIONALS TO SHARE INFORMATION WITH THIS COMMITTEE ABOUT MY CONDITION TO ASSIST IN THE SUPPORT OF THIS REQUEST. I ALSO UNDERSTAND THAT MY MEDICAL INFORMATION WILL NOT BE SHARED WITH ANYONE THAT DOES NOT HAVE A NEED TO KNOW FOR THE PROCESS OF THIS APPLICATION.

SIGNATURE OF APPLICANT, PARENT OR LEGAL GUARDIAN	DATE