Silver Linings Foundation Grant Application

Silver Linings Foundation is a 501(c)(3) charitable organization. The mission of Silver Linings Foundation is to assist America's special needs population and their families by providing them with Medical Care Guides, education, resources, and the equipment they need.

Grants are awarded at the sole discretion of the Silver Linings Foundation Board of Directors. If your grant request is approved, the equipment provider or service provider will be paid directly by Silver Linings Foundation.

Grant Application currently provides equipment to individuals with disabilities who meet the following eligibility criteria:

1. Location - Reside in the United States.
2. Diagnosis - Have a diagnosed physical, mental, and/or sensory disability documented by your current physical / occupational therapist, or personal care physician.
3. Age: Any
4. Application - Current application completed – must be typed.
5. Income - Applicant's household income must meet Silver Linings Foundation grant income guidelines. Income verification will be required.

# Household Members	Household Salary
2	$64,080.00
3	$80,640.00
4	$97,200.00
5	$113,760.00
6	$130,320.00
7	$146,920.00
8	$163,560.00

**For each additional person, add $16,640.*

Letter - Submit a letter from your child's current physical / occupational therapist or personal care physician indicating that the equipment you are applying for would be medically appropriate (**see pages 12-15 for additional information on letter**).

How to Apply:

1. Read the application carefully and complete all information. **PLEASE TYPE.**

2. Attach copies of proof of all household gross income (before taxes and deductions) that reasonably represents your household's current income. If possible, all income documents should be dated within 60 days of the date you apply—if older, Silver Linings Foundation will contact you for more recent copies.

Proof of household income verification is listed below:

- **If a household member is employed:** Two pay stubs from the last 60 days for each person working in the household. Send more pay stubs if pay changes regularly. If you do not get pay stubs, submit a signed and dated letter from the employer on company letterhead which states the hourly rate, number of hours (regular and overtime) worked per pay, frequency of pay and gross pay. Bonus and commission information should be provided, as well.

- **If a household member is self-employed:** Include the most recent federal income tax return and all related tax schedules and forms or submit a year-to-date profit and loss statement showing the business name, time frame being reported, gross income received, only business related expenses by line item, and the net profit. Please sign and date.

- **If a household member is a seasonal or temporary employee:** Indicate the number of months worked during the year and if Unemployment Compensation is received when not working.

- **If a household member receives Unemployment Compensation:** Submit the Notice of Financial Determination award letter or check stubs.

- **If a household member receives Social Security, Survivor's or Disability benefits, retirement, pension, or Worker 's Compensation:** Submit the most recent award letter, a Form 1099, or a bank statement which shows the direct deposits to a bank account.

- **<u>If a household member received child support or alimony:</u>** Submit the support order or a copy of the payment history for the past 12 months. This can be obtained through the state child support enforcement agency or bureau.

<u>You Automatically Meet Silver Linings Foundation Income Guidelines If:</u>

- **<u>Your household is enrolled in the Supplemental Nutrition Assistance Program (SNAP).</u>** Submit proof of enrollment (e.g. documentation of enrollment for the current year).

- **<u>Your child is enrolled in a free/reduced meal program.</u>** Submit documentation from your child's school to acknowledge enrollment.

- **<u>Your child is enrolled in the Children 's Health Insurance Program (i.e. free or low cost only)</u>.** Submit documentation of enrollment or a copy of your child's current CHIP card.

3. When you have completed the application and gathered copies of all necessary supporting documentation, please sign and date the application and return it to Silver Linings Foundation.

Tell us about the individual applying for the grant application:

How did you hear / learn about Silver Linings Foundation Grant Application?		
Last Name: (Applicant)	First Name: (Applicant)	Middle I
Diagnosis (es):		
Date of Birth:	Age:	Gender:
Street Address:		Apt.:
City:	State:	Zip Code: County:
School District Child Resides In (if applicable):	Union Affiliation (if applicable):	
Primary Insurance Company:	Secondary Insurance Company:	
Home Phone Number:	Work/Cell Phone Number:	Best time (circle)
Email Address:		

Please list <u>all</u> the people who live in your household.

Start with yourself:

Please include all adults & children who live with you (Last Name, First Name, M.I.)	Relationship to Child	Sex	Birth Date MM/DD/YYYY
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	

Item or Service you are requesting

_____
_____
_____
_____

How will this Item or Service help you?

_____
_____
_____
_____

Name of Company or Service Provider: _____

Attention: _____

Address: _____

Phone: ( ) _____ Ext. _____ Email: _____

Funding amount requested: $_____

Income and Expenses: Please tell us about the income of any child or adult you have listed on this application. You must send us proof of income.

Earned Income includes income from a job or self-employment. You must send us proof of income. For example, a single pay stub for a person who routinely receives the same amount of wages each pay period is acceptable. If your income changes regularly, send us more income documents. All income documents must be dated within the past 60 days (except tax returns). Send copies — we cannot send originals back to you. Add an additional sheet of paper for additional earned incomes.

Does anyone have income from: **Employment (wages, tips, commissions, bonuses)** ☐ Yes ☐ No **If yes, please fill out the following fields:**	
Whose income is this?	
Employer's Name:	How often is the income received? (weekly, bi-weekly, etc)
Does this income change? (for example, overtime, seasonal, etc) If yes, please explain. ☐ Yes ☐ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of hours worked per year:

Does anyone have income from: **Employment (wages, tips, commissions, bonuses)** ☐ Yes ☐ No **If yes, please fill out the following fields:**	
Whose income is this?	
Employer's Name:	How often is the income received? (weekly, bi-weekly, etc)
Does this income change? (for example, overtime, seasonal, etc) If yes, please explain. ☐ Yes ☐ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of hours worked per year:

For proof of income, please submit copies — we cannot send originals back to you.

Income and Expenses: (continued)

Does anyone have income from: **Employment (wages, tips, commissions, bonuses)** ☐ Yes ☐ No **If yes, please fill out the following fields:**	
Whose income is this?	
Employer's Name:	How often is the income received? (weekly, bi-weekly, etc)
Does this income change? (for example, overtime, seasonal, etc) If yes, please explain. ☐ Yes ☐ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of hours worked per year:

Unearned Income: Includes income from retirement/pension plans, workers' compensation, social security, child support payments, and unemployment benefits. Add an additional sheet of paper for additional unearned incomes.

Does anyone have income from: (Please check Yes, or No).	Yes, No	Whose income is this?	How often is Income received? (weekly, bi-weekly, etc.)	Amount received before taxes & deductions	Does this income change? Yes, N o
Supplemental Security Income (SSI)	❑ ❑				❑ ❑
Pension/ Retirement	❑ ❑				❑ ❑
Workers' Compensation	❑ ❑				❑ ❑
Unemployment Benefits	❑ ❑				❑ ❑
Dividends/ Interest	❑ ❑				❑ ❑
Child Support/ Alimony	❑ ❑				❑ ❑
Public Assistance	❑ ❑				❑ ❑
Social Security (retirement, survivors, disability)	❑ ❑				❑ ❑
Rental Property (You pay some- one to manage.)	❑ ❑				❑ ❑
Other (Specify)	❑ ❑				❑ ❑

Affirmation of Truth:

I (We) stipulate that the information included in this application is true to the best of my (our) knowledge. Further, I (we) understand that the presence of inaccurate information in this application could result in the need for the re-evaluation of this application on the part of Silver Linings Foundation.

_____

Parent/Legal Guardian Date

_____

Parent/Legal Guardian Date

(Signature is required of <u>all</u> parents / legal guardians.)

Release of Liability:

In consideration of the receipt of certain enabling equipment awarded by Silver Linings Foundation, _____ , (the Recipient thereof), him / herself or through his/her parent or legal guardian, hereby releases and forever discharges Silver Linings Foundation, their members, employees and officers (hereafter collectively referred to as "Silver Linings Foundation") from and against any and all claims, of any type, which arise from or are related to:

1. Any alleged malfunction of or defect in the enabling equipment;
2. Any allegation that the enabling equipment was not appropriate or suitable for the Recipient;
3. Any other matter, of any type, related, in any way, to the Recipient's receipt or use of the enabling equipment.

_____

Parent/Legal Guardian Date

_____

Parent/Legal Guardian Date

(Signature is required of <u>all</u> parents / legal guardians).

Disclaimer:

Silver Linings Foundation strives to provide to help individuals increase quality of life and be able to remain living in their home environment. The equipment we provide carries no warranty from Silver Linings Foundation and its use, even in the event of malfunction resulting in injury, gives rise to no liability on the part of Silver Linings Foundation. Silver Linings Foundation is merely a funding source. Silver Linings Foundation is in no way responsible for maintaining or repairing any equipment. It is the sole responsibility of the Recipient's parent (s) / legal guardian(s) to maintain, and /or repair.

Should the equipment no longer be needed (or outgrown), Silver Linings Foundation requires that the parent (s) / legal guardian (s) contact Silver Linings Foundation for equipment to be returned.

Any other costs that may be associated with the equipment such as installation, delivery, labor, disposal, etc. that are not explicitly stated on the application are the sole responsibility of the Recipient's parent (s) legal guardian (s).

Before disbursement of any equipment, the parent (s) / legal guardian (s) of the Recipient must have this form signed, and returned to Silver Linings Foundation.

I have read and fully understand and agree to the above Disclaimer.

I _____
(Parent / Legal Guardian's Name Printed)

_____
(Parent / Legal Guardian's Signature)

am the Parent / Legal Guardian of

_____
(Recipient's Name Printed)

Authorization to Use Name and Likeness:

The Recipient and his/her parents or legal guardians hereby acknowledge and agree that acceptance of the enabling equipment from Silver Linings Foundation may result in publicity. The Recipient and his/her parents or legal guardians hereby irrevocably authorize Silver Linings Foundation: (a) to publicize and use the Recipient's likeness, voice and features, with or without his/her name, for any publication, promotion, trade or business use, or any other purpose; (b) to photograph, videotape, film and record each Recipient in any manner Silver Linings Foundation chooses; (c) to copyright, convey or otherwise distribute, now or in the future, any such material involving the Recipient, his/her parents or legal guardian and that said material may be distributed to anyone, for any purpose, including the general public, magazines, newspapers, television, radio stations; (d) to publicize, now or in the future, the name of the Recipient including information regarding his/her physical condition and details regarding the enabling equipment received from Silver Linings Foundation.

The Recipient and his/her parents or legal guardians agrees that it is not necessary for Silver Linings Foundation or anyone else to contact them prior to releasing any information authorized by this document. The Recipient and his/her parents or legal guardians hereby releases Silver Linings Foundation from and against any and all claims, of any type, which arise from or are related to Silver Linings Foundations use, distribution or disclosure of any photographs, films, videotapes, electronic recording or other information regarding the Recipient and the award from Silver Linings Foundation.

_____

Parent/Legal Guardian Date

_____

Parent/Legal Guardian Date

(Signature is required of <u>all</u> legal guardians.)

(Please note that your signature is not required on this form for the application to be considered by Silver Linings Foundation. However, we do require photos of your child with their awarded equipment. Please note that we will only publish photos of children authorized by families signing this release form. Other phots will be kept confidential. All photos enhance our fundraising efforts to secure additional funding from corporate sponsors, individuals and community foundations to help individuals with disabilities and to continue our programs. Thank you.)

Letter of Medical Justification Format:

The letter of medical justification for Silver Linings Foundation Grant Program application may be completed by the child's current Physical Therapist, Occupational Therapist, or Primary Care Physician.

The letter should be printed on letterhead and signed / dated.

Some essential elements required in the letter of medical justification, include:

- The reasoning behind requesting the equipment / why the current situation is not working.
- Why this equipment would be medically appropriate and for the individual.
- The individual's current height and weight (very important to determine correct sizing).
- Whether or not the individual has trialed the requested equipment.

The professional completing the letter of medical justification should include their full name, title, organization, phone number, and e-mail address.

Letter of Medical Justification SAMPLE:

Medical Necessity/Reasoning for Equipment (Please individualize this for your client):

Date: January 4, 2016

Individual's Name: John Smith

***D.O.* B:** March 14, 2004

Diagnosis (es): {listing of individual's diagnosis}

BODY OF YOUR LETTER: (SEE BELOW) **http://sleepsafebed.com/about-insurance/sample-letters/**

Equipment Prescribed: http://sleepsafebed.com/products/choosing-your-bed/

Equipment Prescribed: The SleepSafe® 2

Transfer Height: Medium **Bed Feature or Foundation:** Full length safety rails, Electric with HI-LO Foundation **Bed Size**: Twin **Wood Finish**: Cherry **Additional Accessories:** Padding in Gray, and Medical Tubing, IV Pole, Windows in the side rails.

http://sleepsafebed.com/about-insurance/sample-letters/

The following example letter of medical necessity and advice are only intended to assist you in writing your own letter to aid in securing funding for medical equipment. It is in no way implied that if you use this example you will be granted funding for medical equipment. Our only intention is to share information that we have gathered in the past and used by other clients.

The funding agencies that would be in charge of compensation for such medical items, such as your insurance company or a private philanthropic organization, almost always demand a letter of medical necessity from a therapist (physical, occupational, or otherwise) or from a physician to prove your claim that your child's medical equipment was necessary to his successful treatment. The claim or appeal will be likely be refused if you do not include a letter of medical necessity which includes a detailed explanation of the condition or disability that makes the equipment a necessity for your loved one.

It is possible that your particular physician may not fully be acquainted with the rules of your insurance company which will affect whether or not you are reimbursed for your child's medical equipment. (Each insurance company or state may have slightly different rules.) To be on the safe side, educate yourself on the rules so that you can be a better advocate for your family. You should become familiar with the bare minimum of information that needs to be included in a letter of medical necessity. Otherwise, the letter may contain insufficient information, which may lead to the funding agency denying your claim.

Equipment Justification

May 4, 2016

To Whom It May Concern (or, better, to a specific employee of the funding agency):

RE: Johnny Smith

DOB: 01/01/01

Patient Info:

Johnny is a male, 11 years, 9 months old. Johnny lives at home with his mother and father. His mother is his primary caregiver. He has a diagnosis of Pierre-Robin Syndrome and Trisomy 22. His medical his-tory includes: seizures, scoliosis, allergies, G-tube, limited vision and multiple hospitalizations. Medication is taken for seizures and allergies.

Johnny is 48" long (with knee flexion contractures) and weighs 60 pounds. He uses a manual wheelchair for dependent positioning and mobility. He sits with posterior pelvic tilt and rounded shoulders. Given trunk support he will take weight on his lower extremities to complete a standing pivot transfer. His cur-rent wheelchair seat height to floor is high, making transfers difficult. As he is getting heavier to transfer so we are actively working to improve his self-transfer skills. He has limited active lower extremity movement using adaptive walking equipment. He has functional head and trunk control in sitting. He has active floor mobility by

scooting. He needs assistance to transition to/from the floor. He has low muscle tone and decreased muscle strength. Protective reactions are limited and he lacks safety aware-ness. Tight hamstrings affect his positioning. Johnny is dependent to all self-care activities. He is on continuous feedings using a G-tube.

Current Situation:

Johnny currently sleeps in a standard hospital bed with a manual crank for head adjustment. There is no foot or mattress height adjustment. The bed has partial safety rails at the shoulder and the foot section. Prior to the hospital bed, Johnny slept in a standard twin size bed. After numerous falls from the standard bed, he acquired a standard hospital bed. He has fallen from his current bed many times by sliding through the opening in the middle, unprotected section of the bed. His mother has found Johnny entrapped in several different ways on numerous occasions with his limbs entangled within the openings of the partial safety rails. His current bed does not allow for foot adjustment so when his head is elevated for G-tube feedings he slides down the mattress, putting tension on his feeding tube. Wedges and pillows have been tried, but Johnny has been able to wiggle and kick them out of position. His current bed does not have mattress height adjustability, making self-transfers nearly impossible as the bed is too low for Johnny to bear weight and stand tall enough to transfer to his chair. Another option that was considered to prevent injury from falls or entrapment was to simply put a mattress on the floor, however this made it impossible for Johnny to be given the care necessary for his various conditions. It would also prevent Johnny from being able to go from bed to chair for mobility and aid in his daily living. Similar special needs beds with safety rails were considered, such as the Stockton or a Pedicraft. However, these beds did not prove to be a lower cost alternative after adding the necessary 'options' to the base model that would bring those beds up to the safety standards of the bed being recommended below.

Recommendations:

We are recommending that Johnny obtain a SleepSafe II – Medium Bed with Hi Lo foundation to ensure his safety. This bed provides a precision fit mattress that prevents burrowing and entrapment. The mat-tress is a Visco Elastic pressure relieving foam mattress which will assist in maintain his skin integrity. The full length safety rails prevent Johnny from falling from bed or becoming entrapped in them. The safety rails have clear non-breakable windows that allow freedom of visual interaction (needed to monitor his overall condition) and allows him a safe area when unsupervised. The Hi Lo component of the electric foundation will allow the bed to be adjusted to the appropriate height that will allow Johnny to transfer by stand pivot. The adjustable head and foot component of the electric foundation allows his head to be elevated which will relieve spinal pressure, alleviate respiratory issues and is needed during continuous feeding through his G-tube. The adjustable foot section allows assistance in positioning Johnny when his head is elevated. Without the foot adjustment, he would continue to slide down the mattress surface, increasing the chance of displacement of his G-tube. An IV pole is needed for feeding Johnny. The SleepSafe II – Medium bed with hi lo foundation will allow Johnny to have a safe sleeping environment, assist in a self, stand pivot transfers from bed to chair and allow

for proper positioning as he grows, without concerns of potential injury from falls or entrapment. The features, solid construction and sufficient size of the bed will meet his needs for years to come, into his adulthood.

Thank you for your time and consideration of Johnny's needs. If you have further questions I can be contacted at (555) 555-1111.

Sincerely,

Name of Professional:

Title:

Organization:

Phone Number:

E-mail Address:

***Silver Linings Foundation is a supplier of last resort. You will need to have your letter of medical necessity submitted to your insurance company and if applicable Medicaid. If the letter of medical necessity is denied, you will need to have gone through the appeals process as well.

The steps of that are taken when a Letter of Medical Necessity is needed:

- ☐ You contact the individual's primary care physician:
- ☐ They write the LMN (Letter of Medical Necessity)
- ☐ They fax it to your DME (Durable Medical Equipment) Company.
- ☐ The DME company faxes the LMN along with the MA-97 form to your Insurance companies.
- ☐ It is wise to follow up with your DME provider: Have you received the LMN? Have you submitted the LMN and the MA-97 to our insurance providers?
- ☐ Once you get the approval or denial: Make sure the DME Company places your order, or that you get started with the appeal process. You can enlist the help of your physician to do so. You can also go through your DME company from the very beginning. They can write your LMN and help with the appeal process.

Be sure to take note of when your child's letter was sent to the funding agency, and if three or four weeks pass without word from them, you might want to call the agency to inquire about the status of your claim. Always keep a record of when you call and with whom you speak to, and always try to remain calm and collected when dealing with the insurance company. If, however, you are unable to obtain a straightforward response as to when your claim will be processed, do not hesitate to enlist the help of your physician.

"Silver Linings Grant Application" Checklist:

- ☐ Completed Silver Linings Grant Application in full and submitted.
- ☐ Copies of appropriate income verification information submitted.
- ☐ A letter from a physical or occupational therapist, or a personal care physician indicating that an adaptive bicycle would be medically appropriate and the individual and that something else would not be appropriate.
- ☐ Signature on Release of Liability form, Affirmation of Truth Statement, & Disclaimer.
- ☐ Authorization to Use Name & Likeness (signature optional).
- ☐ Remember to upload your other forms (income verification information, letter of medical necessity, information on product if necessary.

1. Do not include personal photos or any information not requested.
2. **Email** only completed applications and supporting documentation to the Foundation at: info@silverliningsfoundation.org
3. Emailed applications must be received by March 1, 2017 at 11:59 pm Eastern Standard Time.

   or

4. Please **mail** the application and supporting documentation to:

   Silver Linings Foundation
   Attn: Application Review
   832 11th Ave
   York, PA 17402

5. Application MUST be postmarked by March 1, 2017.

Notification of the Foundation's determination will be sent to applicants via standard U.S. mail approximately eight weeks from the deadline. We may contact you for further information.

If you have any questions, please contact us via email at info@silverliningsfoundation.org

Thank you for your interest in Silver Linings Foundation Grant Application!