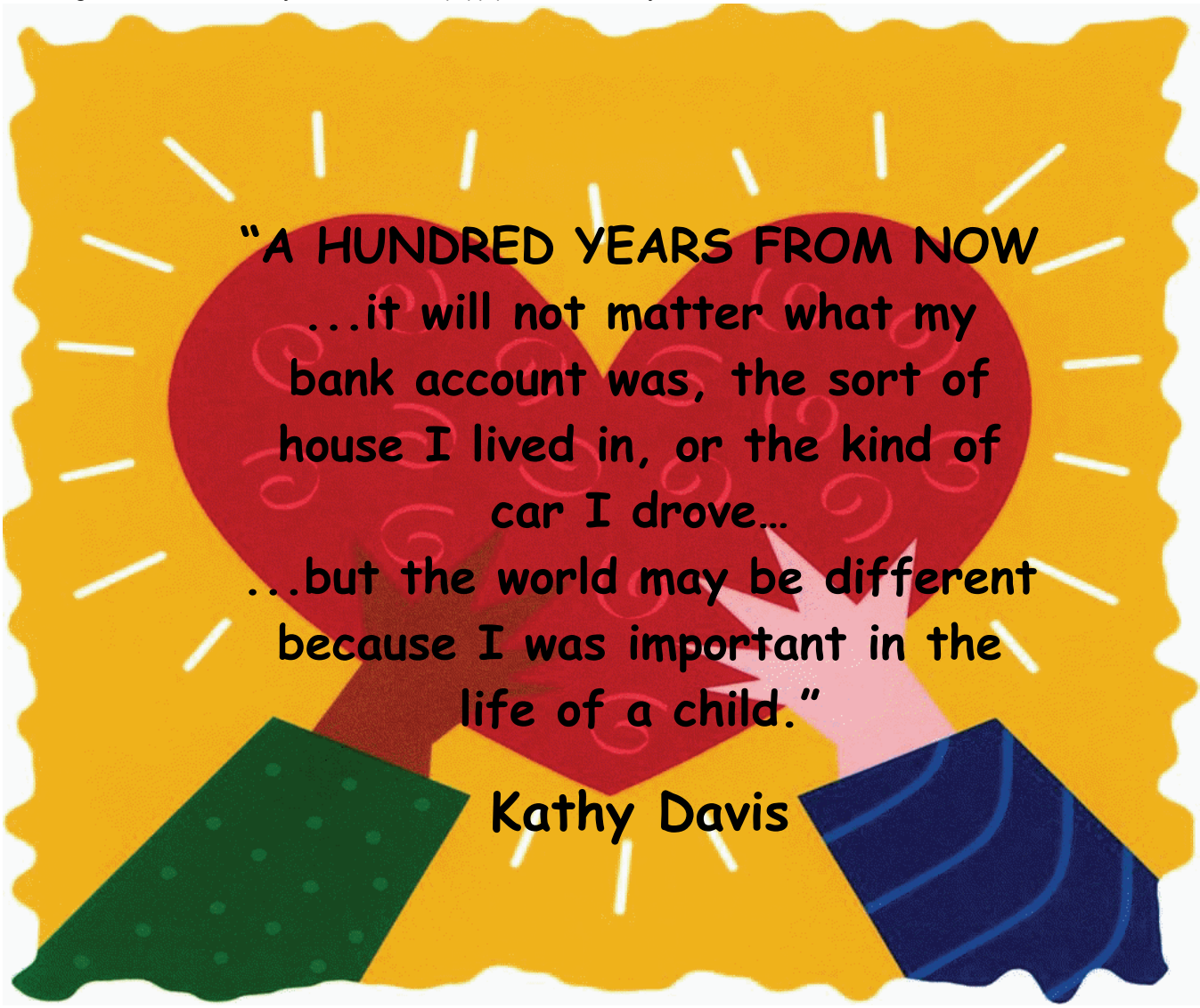
MCCD

Midwest Council for Children withDisabilities

301 High Grove Blvd. Glendale Heights, IL 60139

A Registered NFP Charity • IRS 501(C)(3) • Attorney General ID# 01041315 • FEIN # 36-4378294



MCCD provides families of disabled children the means to pursue medical treatments and therapies not covered by health insurance

100% OF EVERY DOLLAR RAISED, AFTER THE COST OF AN EVENT, IS USED FOR THE CHILDREN

Name _____ Date _____

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To be considered for assistance, you must complete an application. Completing the application is in no way a guarantee that you will be granted funding.
Once you have completed and submitted the online portion of your application, a confirmation message will be sent. After all required documentation is received, your application will be processed based on our eligibility criteria and the information you provided. A separate application is needed for each child.
Applying for assistance should not require hours of endless paperwork. At MCCD, we respect your personal time and know that spending time with family and friends is what really matters.
That's why we've created a quick online application process that is user friendly and easy to complete. The MCCD family is committed to meeting your needs as quickly as possible!
This form consists of 5 pages, and requires submission of your latest tax returns.

Description of Service / Therapy / Equipment

Contact Info of the Provider

Name | Affiliation

Address | City | St | Zip

E-Mail | Phone

Frequency of Service | **Cost per Session** | **Annualized Cost**

☐ Weekly ☐ Monthly ☐ Yearly ☐ One Time Grant

Detail all other costs associated with this request:

Description of Service / Therapy / Equipment

Contact Info of the Provider

Name | Affiliation

Address | City | St | Zip

E-Mail | Phone

Frequency of Service | **Cost per Session** | **Annualized Cost**

☐ Weekly ☐ Monthly ☐ Yearly ☐ One Time Grant

Detail all other costs associated with this request:

Office use below this line

Date of Review		Board Initials			
Date of Family Grant Acceptance					

Name _____ Date _____

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Please detail how you learned about MCCD.
(Please attach an additional sheet if needed.)

It is common procedure for a therapist or provider to assess a child prior to the start of therapy and see what areas the child needs to work on. Goals are then written and progress is monitored to ensure the therapy is meaningful.

In order to ensure functionality of service, please attach provider's assessment and goals for the upcoming year

Child

Name _____ Date of Birth _____

Diagnosis _____

Primary Doctor _____ Phone _____

Specialist _____ Phone _____

Insurance Provider _____

Current Therapies	Provider	Times/Wk	Insurance Y/N	Co-Payment $
			No	
			No	
			No	
			No	
			No	

Past Therapies: Type	Provider	Approximate Last Date Received

Name _____ Date _____

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Parent

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Employer _____ Position _____ Years w/Co _____

Employer Address _____

City _____ State _____ Zip _____

Insurance Provider _____

Spouse / Other Parent

Name _____

Address (if different) _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Employer _____ Position _____ Years w/Co _____

Employer Address _____

City _____ State _____ Zip _____

Insurance Provider _____

Please list the Name(s), Ages(s) and Relationship(s) **of all other Residents Living in the Same Household:**

Name	Age	Relationship

Name _____ Date _____

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Monthly Income

Parent

Gross Salary	$
Social Security/Disability	$
Pension	$
Alimony/Child Support	$
Other:	$

Spouse / Other Parent

Gross Salary	$
Social Security/Disability	$
Pension	$
Alimony/Child Support	$
Other:	$

Child(ren)

Social Security/Disability	$
Other:	$
Other:	$

Income Contributed by any Other Household Resident $

Total Monthly Income $

Assets

Home Equity	$
Savings Accounts	$
Checking Accounts	$
Stocks and Bonds	$
Auto(List)	$
Other	$

Monthly Expenses

Federal Income Taxes	$
State Income Taxes	$
F.I.C.A. Taxes	$
Retirement	$
Rent	$
Mortgage	$
Real Estate Taxes	$
Utilities	$
Food	$
Transportation	$
Life Insurance	$
Car Insurance	$
Medical (incl. Insurance)	$
Education Costs	$

Loan Payments (List)

	$
	$
	$

Other (Specify)

	$
	$
	$

Total Monthly Expenses $

Are you currently receiving assistance from other organizations? Y / N No

Early Intervention ☐ SSI ☐ DJFS ☐ DSOC ☐ WIC ☐ County Board ☐ Other ☐

Please attach a **COMPLETE** copy of last year's Federal Income Tax Return.

Click this button to Print this Form and FAX to: 440-891-0647 **Print**

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www.mccdcares.com

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Family Grant Acceptance

As part of the grant application, the Midwest Council for Children with Disabilities encourages applicants to commit to assist in fundraising efforts. Opportunities will be provided to you over the course of the year to assist you in achieving your goal, including, but not limited to:

Sales of raffle tickets for various prizes to support all MCCD chapters
Registration/Sponsorship forms for our Annual Golf Outing
Listing of items needed for our live and silent auctions
Schedules and communications for new MCCD fundraising activities
Schedules and communications to support fundraisers for all chapters

Please be aware that we understand your time is a valuable resource. We have developed a matrix to determine the amount of assistance that we encourage. Remember, the assistance can be anything from your ticket sales, to making a set number of phone calls to supporters, to assisting with a new fundraiser. Any member of your family is welcome to participate towards your allocated hours. While the following matrix indicates 'hours', our system allows for the incorporation of donations and/or sales to equal time.

If your family receives $X for the year, your family will be encouraged to donate time/effort equivalent to:

$1000 or less = 4-hours, or equivalent
>$1001- $1350 = 6 hours, or equivalent
>$1351- $2600 = 10 hours, or equivalent
>$2601- $4000 = 15 hours, or equivalent

Please understand that the achievements of your fundraising goal will be reviewed and may be used as a factor in your child receiving assistance in the future. Your family will not be financially responsible for any shortfall in your family reaching its fundraising goal.

My signature below indicates that the information presented in this application is accurate to the best of my knowledge, and that I understand the importance of my fundraising goal.

_____ Date _____

Printed Name

_____

Signature

In Illinois • 301 High Grove Blvd • Glendale Heights, IL 60139 • (630) 539-5977
In Ohio • 23818 Cooper Turn • Olmsted Falls, OH 44138 • (440) 891-6222
In Wisconsin • 21 S. Lake Street PO Box 86 • Elkhart Lake, WI 53020 • (920) 207-4561