

MCCD

Midwest Council for Children with Disabilities

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
<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> 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
<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> One Time Grant			
Detail all other costs associated with this request:			

<small>Office use below this line</small>			
Date of Review	_____	Board Initials	_____
Date of Family Grant Acceptance	_____		

Name _____

Date _____

MCCCD

Midwest Council for Children with Disabilities

Please detail how you learned about MCCCD.
(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 \$

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

Monthly Expenses

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

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	\$	

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	\$	
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Loan Payments (List)		
	\$	
	\$	
	\$	

Total Monthly Income	\$	
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Assets		
Home Equity	\$	
Savings Accounts	\$	
Checking Accounts	\$	
Stocks and Bonds	\$	
Auto(List)		
Other		

Other (Specify)		
	\$	
	\$	
	\$	

Total Monthly Expenses	\$	
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Are you currently receiving assistance from other organizations? Y / N

Early Intervention SSI DCFS DSCC 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 Email: j_petruziello@pointoneintl.com

Click this button to encrypt your information and attach via E-Mail.If your E-mail application is inactive, Please Email:j_petruziello@pointoneintl.com