Charitable Foundation Program
Application for Assistance

Complete the information below and return the application to the **Joseph Thomas Foundation, 238 Sugar Biscuit, Abilene, Texas 79602**. To be eligible, applicants must have custody of a medically fragile child with a mental or physical impairment that substantially limits one or more major life activities. The impairment may be congenital or acquired by accident, injury or disease.

Applications are approved by the Board of Trustees on a quarterly basis. The deadlines for these applications are: March 31, June 30, September 30 and December 31. Applications must be received by 4:30 p.m. on or before the deadline date. Faxed applications will not be accepted. Funds will not be awarded to cover the cost of goods purchased or services performed prior to this application. Applications that do not meet criteria will be denied.

All applicants will receive written notice of approval or denial of the application. Foundation staff is available to answer questions. We can be reached at 325-692-3159.

Date:

1. **Applicant Information**
   Name of Child:
   Name of Applicant:
   Street Address:
   State: City: Zip:
   Phone:

2. **Representative Information**
   Name of Representative:
   Organization:
   Street Address:
   State: City: Zip:
   Phone:

______________________________ ______________________
Applicant Signature Date

______________________________ ______________________
Agency Representative Date

3. **Date of Child's Birth:**

4. **Type of Disability:**
   - ☐ Mental Retardation or Developmental Disability
   - ☐ Brain Injury
   - ☐ Orthopedic
   - ☐ Other (specify)

5. **Living Situation of Applicant:**
   - ☐ Lives with family (biological, relatives, or adoptive)
   - ☐ Lives with foster family
   - ☐ Lives in supported living setting (less than 24 hour staff supervision)
   - ☐ Lives in supervised living setting (24 hour staff supervision)

     Type of living setting (check one):
     - ☐ Staffed Apartment
     - ☐ Group Home
     - ☐ State-operated facility (specify)
     - ☐ Nursing Home
     - ☐ Other (specify)

6. **Applicant Receives the Following Public Benefits (check all that apply):**
   - ☐ SSI $ per month
   - ☐ SSDI $ per month
   - ☐ Food Stamps
   - ☐ Medicaid
   - ☐ Medicare
   - ☐ Other Benefits (specify)
   - ☐ Applicant receives no public benefits

7. **Applicant Income:**
   If applicant is less than 18 years of age:
   7a. Number of persons in the family unit:
   7b. Gross Annual Income of the family: $

8. **Type of Assistance Requested (check one):**
   - ☐ Medical and dental care and equipment
   - ☐ Rehabilitation training, services or devices
   - ☐ Supplemental education assistance
   - ☐ Personal goods and services
   - ☐ Transportation

9. **Describe the specific item or support that is requested.**

10. **Briefly describe the applicant's situation. Include why the item or support requested in 9 (above) is needed, and how it will benefit the recipient.**

11. **Amount Requested:**
NOTE: An estimate or invoice from a vendor or other documentation of the cost of the item(s) requested must be enclosed. If the request if for dental care a treatment plan must be enclosed with the application.)

    $

12. **Has an effort been made to secure funding for the requested item or support through other sources?**
☐ Yes ☐ No
12a. If yes, to whom (agency or resource) was the request made?
12b. Has the request been denied? ☐ Yes ☐ No
12c. What was the reason for denial?

FURTHER REQUIREMENT:

A letter of recommendation from a Physician must accompany this application. The letter must be signed with the Physician's address and phone number included.