

SCI Special Fund

A NON-PROFIT INCORPORATION FOUNDATION – I.D. #33-0310017

Dear Potential SCI Recipient,

The SCI Special Fund is designed to help people living with spinal cord injuries. *The mission of the SCI Special Fund is to assist individuals with spinal cord injuries to gain independence through life changing grants.* Examples of items funded by the SCI Special Fund include, but are not limited to:

- Hand controls
- Automated turning mattresses
- Shower chairs
- Standing frames

Attached you will find an Application Packet which includes:

- Application/ Biographical Information Request Form
- Verification of Disability Form (*must be filled out by your doctor*)
- Letter of Recommendation Request

Please provide the requested information and include a letter explaining why you need funding. Once this information is received and reviewed, you will be contacted to arrange an interview. The SCI Special Fund cannot commit to funding each request that is submitted. Requests are evaluated independently based on need and overall ability to benefit from the services requested. Also please be aware that the grants are funded on a one-time-only basis.

NOTE: You must be a citizen of the United States or a legal resident living in the state of California to receive services from this fund. Proof may be required.

Please return the completed information via mail, fax or email to:

**Elizabeth Toumajian
C/O SCI Special Fund
1601 E. St. Andrew Place
Santa Ana, CA. 92705**

Phone: 714-361-6180 ext. 240

Fax: 714-361-6190

Email: etoumajian@hotmail.com

Application / Biographical Information

All information will be considered strictly confidential for the use of the SCI Special Fund only.
Awards are made without regard to the applicant's race, creed, national origin, gender, age, or disability.

() Mr. () Ms. _____
Last Name First Name M.I.

Street Address: _____
Number and Street Apt./Unit #

City, State, Zip: _____

Phone: _____
Home Work email address

Birthdate: ____ Age: ____ Gender: ____ Male ____ Female
mm dd yyyy

Marital Status: __ Single __ Marr. __ Separated Do you live with your parents? ____
Y N

Are you a single parent? ____ Number of dependents: ____
Y N

Are you working? ____ If yes, where? _____
Y N

How many hours per week? ____ Supervisor's name: _____

Company address/phone number _____

Do you have a disability? ____ If yes, please describe: _____
Y N

What are your career goals? _____

What are your educational goals? _____

What is your annual income? ¹ \$_____ What is your parent's annual income? ² \$_____

Describe what your need is in DETAIL and how it will change your current situation.

¹ Please provide Adjusted Gross Income from the previous year filed.

² Please provide Adjusted Gross Income from the previous year filed.

SCI Special Fund

How much do you think your project/need will cost? \$ _____

Please provide copies of any quotes for equipment use. If you are asking for equipment such as computers for educational purposes please submit a copy of your school transcript showing proof that you are currently attending classes. Any specific requests by a doctor or therapist should accompany a recommendation from that professional. The more information that you can provide the easier it will be to determine your eligibility.

Letter of Recommendation:

Letter of Recommendation Request – Please submit a letter of recommendation from someone who can attest to your personal or career accomplishments and/or goals (in regards to school, employment, etc.). Please have this person include their name and contact number at the close of the letter so that we can contact them for reference purposes.

Thank you!

SCI Special Fund Medical Verification of Disability

Name of potential recipient _____
Last name First name MI

Birthdate (mm/dd/yyyy) _____ Social Security # _____

[I authorize you to release from your records any information regarding my medical and/or health conditions to the SCI Special Fund. All records maintained by the SCI Special Fund personnel pertaining to the named potential recipient are protected from disclosure and are subject to all other requirements of confidentiality. Participation with the SCI Special Fund is entirely voluntary; however, these records will be held in confidentiality at the SCI Special Fund office and may be retrieved only by the named potential recipient after signing a release form.]

Signature of potential recipient _____ Date _____

Please name the Physician, Specialist or Agency who can provide verification of your disability

Name _____

Title/Professional designation _____

Address, City, State, Zip _____

Phone # _____ email address _____

To the Physician/Specialist/Agency:

Please check all of the following that apply to the potential recipient's disability. It would also be beneficial if you would list the degree, progressive factors involved, and/or any limiting effects of the disability. Such documentation may be provided in the space below or by forwarding tests or other verification.

Progressive Factor(s) _____

Medication _____

Side Effects _____

Diagnosis _____

Description of Functional Limitation _____

Signature of Physician/Specialist

Title/Position

License #