

DISABILITIES COMMITTEE
ROTARY CLUB OF SPOKANE #21
PMB-373
2525 E. 29TH AVENUE, SUITE 10-B
SPOKANE, WASHINGTON 99223

INSTRUCTION FOR DISABILITY APPLICATION FORM

The Disabilities Committee of Rotary Club of Spokane #21 meets the third Tuesday of every month to review applications and make recommendations on funding Disability Accommodations to the Rotary Club's Board of Directors. To expedite your application process, please ensure all parts are filled out completely. Incomplete forms will be returned to the applicant without processing. Additional application forms may be requested from the Disabilities Committee at the following address:

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- Make sure signature of person authorized to release confidential information is attached.
- Attach picture if requesting medical equipment, with specifications and costs included.
- Attach letter of history and justification for desired equipment from Primary Care Physician or other appropriate specialist.

Send completed application forms (3 pages) to:

DISABILITIES COMMITTEE
ROTARY CLUB OF SPOKANE #21
PMB-373
2525 E. 29TH AVENUE, SUITE 10-B
Spokane, Washington 9922

DISABILITY APPLICATION FORM

HOW DOES YOUR DISABILITY AFFECT YOUR DAILY LIVING?

Part D – Accommodation Request

PROVIDE A DETAILED DESCRIPTION OF THE REQUEST. PROVIDE A TOTAL COST FOR THIS ACCOMODATION (INCLUDE ALL PROCESSING, SHIPPING AND HANDLING CHARGES AND ALL APPLIED TAXES). IF APPLICABLE, INCLUDE A QUOTE FROM THE LOCAL DISTRIBUTER OR RE-SELLER WITH NAME OF THE MANUFACTURER, MODEL #, AND VENDOR NAME AND CONTACT INFORMATION.

TOTAL COST OF ACCOMODATION \$

Part E – Financial Request

LIST THE APPLICANT'S **HOUSEHOLD** MONTHLY INCOME AND EXPENSES.

INCOME	AMOUNT	EXPENSE	AMOUNT		
WAGES & TIPS		RENT/MORTGAGE			
DISABILITY		INSURANCE			
RETIREMENT/ SOC. SECURITY		FOOD & TRANSPORTATION			
OTHER		OTHER			
TOTAL INCOME		TOTAL EXPENSE		REMAINING INCOME	

LIST **ALL OTHER** SOURCES THAT HAVE BEEN CONTACTED TO HELP FUND THIS REQUEST

NAME OF FUNDING SOURCE	CONTACT NAME / TELEPHONE NO.	AMOUNT REQUESTED	AMOUNT APPROVED	IF DENIED, PLEASE EXPLAIN...
TOTAL AMOUNT APPROVED BY OTHERS				

DISABILITY APPLICATION FORM

SUMMARY OF ESTIMATED FINANCIAL REQUEST (TO BE COMPLETED BY PREPARER)	AMOUNT	SUMMARY OF ACTUAL FINANCIAL REQUEST (TO BE COMPLETED BY DISABILITIES COMMITTEE)	AMOUNT
TOTAL COST OF ACCOMMODATION (PART D)		TOTAL COST OF ACCOMMODATION (PART D)	
REMAINING MONTHLY INCOME FOR APPLICANT		REMAINING MONTHLY INCOME FOR APPLICANT	
TOTAL AMOUNT FUNDED BY OTHERS		TOTAL AMOUNT FUNDED BY OTHERS	
AMOUNT REQUESTED		AMOUNT FUNDED	

Part F – Preparer’s Information (if different than applicant)

NAME	PHONE NO. (DAYTIME)	PHONE NO. (EVENING)	E-MAIL ADDRESS	
STREET ADDRESS	CITY		STATE	ZIP CODE
WHAT IS YOUR RELATIONSHIP TO THE APPLICANT?		WHAT IS THE BEST TIME AND METHOD TO REACH YOU?		

Part G – Release of Information

I AUTHORIZE RELEASE OF THIS INFORMATION FOR THE USE AND PURPOSE OF THE ROTARY DISABILITIES COMMITTEE TO CONSIDER MY REQUEST FOR FUNDING. I UNDERSTAND THIS INFORMATION WILL BE SHARED WITH COMMITTEE MEMBERS AND OTHER ALLIED PROFESSIONALS, AS NEEDED, WHO MAY BE INVOLVED IN SUPPORTING THIS REQUEST. I FURTHER GRANT PERMISSION FOR ALLIED PROFESSIONALS TO SHARE INFORMATION WITH THIS COMMITTEE ABOUT MY CONDITION TO ASSIST IN THE SUPPORT OF THIS REQUEST. I ALSO UNDERSTAND THAT MY MEDICAL INFORMATION WILL NOT BE SHARED WITH ANYONE THAT DOES NOT HAVE A NEED TO KNOW FOR THE PROCESS OF THIS APPLICATION.	
SIGNATURE OF APPLICANT, PARENT OR LEGAL GUARDIAN	DATE