



65 Willowbrook Boulevard – 2nd Floor
Wayne, New Jersey 07470
(973) 256-8484 VOICE / TTY
(973) 256-1233 FAX

Dear Applicant:

Thank you for your interest in **The Special Needs Fund of Helpful Hands: The Northeast Regional Early Intervention Collaborative, Inc.** A Committee of volunteers meets regularly to review applications and determine financial assistance awards. So please complete the application and return it as soon as possible.

The Special Needs Fund is supported solely by private donations and is subject to the success of Fundraising activities. Due to the limited availability of funds, assistance may not exceed \$500 a year.

Although a family may re-submit an application after having previously received an award, priority consideration is given to first time applicants.

If you have any questions, please do not hesitate to contact me at 973-256-8484.

Thank you.

Sincerely,

Patricia L. Ciccone
Executive Director

**THE SPECIAL NEEDS FUND OF HELPFUL HANDS:
THE NORTHEAST REGIONAL EARLY INTERVENTION COLLABORATIVE, INC.**

Purpose: To provide assistance to families of infants and toddlers with disabilities under age 3 impacted by the high costs of supports/services not covered through Part C, medical insurance, MEDICAID and/or other private or public funding sources.

Eligibility Criteria:

1. Applicant must be resident of and receive Part C early intervention services in Bergen, Hudson or Passaic Counties, New Jersey.
2. Applicant must be the primary legal care giver(s) for the infant or toddler.
3. Applicant must have a signed Individualized Family Service Plan (IFSP) in which the requested service(s) or device(s) are:
 - A. Related to the stated outcomes.
 - B. Identified on the IFSP Service Pages.
4. Applicant must complete and sign the full application and submit it with the following attachments.
 - A. Dated copies of bills, invoices or receipts along with statement(s) of partial payment/rejection of benefits from insurance, MEDICAID, and/or other public or private funding sources.
 - B. A letter written by the parent/caretaker stating why they are requesting assistance from the Special Needs Fund.
 - C. A letter of support from the child's Special Child Health Services Case Management Unit Service Coordinator. (An additional letter of support from the Early Intervention Provider may also be submitted).
 - D. A copy of the current IFSP.

Eligible Services and Equipment:

1. Community Activities/Programs as identified in IFSP.
Example: Membership, tuition or other support, which helps child participate in community activities with children who do not have disabilities. Community activities could include, YMCA swimming lessons, Gymboree, story-time at the library, etc.

Services and Equipment NOT Eligible for Assistance by the Special Needs Fund: Medical Services (diagnostic evaluations); Clothing, unless adaptive in nature; Insurance co-payments; Diapers; Formula and nutritional supplements; Services/Supports not listed on the IFSP service pages.

2. Adaptive/Assistive Devices/Orthopedic Equipment:
For example: Any item, piece of equipment, or toy that is used to increase, maintain, or improve the functional capabilities of children with disabilities.

Special Requirements for Devices or Equipment

- A. A statement of need signed by a physician or medical professional must be attached to application. (Except for adapted toys)
 - B. If the funds requested will only partially support the purchase of the device or equipment, an explanation of how the remaining balance will be paid (such as, time payments, personal loan, other foundations, a community fundraising, etc.)
3. Respite/Child Care Services
Definition: Child care or respite services to help meet the needs of the family and primary care providers.
 4. Conferences
Definition: Conference or Workshop registration related to child's special needs.

Time Lines for Submission of Awards of Assistance:

1. Expenses submitted may not be more than 1 year old as of the date of submission of the application.
2. Applications should be mailed to:
The Special Needs Fund
HELPFUL HANDS - NREIC
65 Willowbrook Blvd., 2nd Floor
Wayne, New Jersey 07470

Decision Process for Assistance:

Decisions on the provision of assistance will be made by a volunteer committee appointed by the Executive Board of the NREIC. The committee will include a parent of a child who receives or previously received Part C Early Intervention Services, a representative of the Executive Committee of the Board of Trustees, and an Early Intervention Professional who is familiar with the needs of infants and toddlers with disabilities and their families.

Assistance will not exceed FIVE HUNDRED DOLLAR (\$500) per year and will be limited by the availability of financial resources within the NREIC Special Needs Assistance Fund.

THE SPECIAL NEEDS ASSISTANCE FUND IS SUPPORTED SOLELY BY PRIVATE DONATIONS AND IS NOT PART OF NEW JERSEY'S STATE-FUNDED EARLY INTERVENTION PROGRAM.

**THE SPECIAL NEEDS FUND
OF HELPFUL HANDS: THE NORTHEAST REGIONAL EARLY
INTERVENTION COLLABORATIVE, INC.**

APPLICATION

PLEASE PRINT:

Child's Name: _____ Date of Birth: _____

Date of Most Recent IFSP: _____ Name of Service Coordinator: _____

Have you previously submitted an application? ___No ___Yes if yes, Date: _____

PARENT/CARETAKER INFORMATION

Name(s): _____ Name(s): _____

Address: _____ Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

County: _____ County: _____

How long resident of New Jersey? ____ How long resident of New Jersey? ____

Phone: (home) _____ Phone: (home) _____

(work) _____ (work) _____

CURRENT EMPLOYMENT INFORMATION

Principal Place of Employment: _____ Principal Place of Employment: _____

Street Address of Employer: _____ Street Address of Employer: _____

City, State, Zip: _____ City, State, Zip: _____

Occupation: _____ Occupation: _____

() Full-time () Part-time () Self-Empl. () Full-time () Part-time () Self-Empl.

I have attached the following:

- ___A. Dated copies of bills, invoices or receipts along with statement(s) of partial payment/rejection of benefits from insurance, MEDICAID, and/or other public or private funding sources.
- ___B. A parent/caretaker letter requesting assistance.
- ___C. A letter of support from the child's Special Child Health Services Case Management Unit Service Coordinator.
- ___D. Copy of Current IFSP.
- ___E. A statement of need signed by a physician or medical professional. (For Adaptive/Assistive Devices/Orthopedic Equipment only)
- ___F. A statement describing how the remaining balance bill will be paid (If exceeds the amount requested)

I certify that:

- 1) these expenses are related to the needs of my child as identified on his/her IFSP.
- 2) these expenses were not paid by any other source.
- 3) all the information contained in this application is true.
- 4) the financial assistance will be used for the approved purposes.
- 5) the final determination of eligibility will be made the NREIC.

Signature of Applicant

Date

Please forward payment directly to the following provider: _____

Signature of Applicant

Date

Child's Name: _____

Date of Birth: _____

Child's Name: _____ Date of Birth: _____

ADAPTIVE/ASSISTIVE DEVICES/ORTHOPEDIC EQUIPMENT

DATE	DEVICE/EQUIPMENT	COST	INSURANCE/ MEDICAID	OTHER FUNDING SOURCES	DIFERENCES

TOTAL ADAPTIVE/ASSISTIVE DEVICES/ORTHOPEDIC EQUIPMENT \$ _____

RESPITE/CHILD CARE SUPPORT

DATE	RESPITE/CHILD CARE	COST	INSURANCE/ MEDICAID	OTHER FUNDING SOURCES	DIFERENCES

RESPITE/CHILD CARE SUPPORT SERVICES TOTAL \$ _____

Child's Name: _____ Date of Birth: _____

COMMUNITY ACTIVITIES SUPPORT

DATE	COMMUNITY ACTIVITY	COST	INSURANCE/ MEDICAID	OTHER FUNDING SOURCES	DIFERENCES

COMMUNITY ACTIVITIES SUPPORT TOTAL \$ _____

CONFERENCES

DATE	CONFERENCE	COST	INSURANCE/ MEDICAID	OTHER FUNDING SOURCES	DIFERENCES

CONFERENCE REQUESTED \$ _____

For office use only: Date: _____ Initials: _____

\$ _____ Adaptive/Assistive Devices/Orthopedic Equipment

\$ _____ Respite/Child Care Support

\$ _____ Conferences

\$ _____ Community Supports

=====

\$ _____ Total Approved (not to exceed \$500 year)

**PARENT/GUARDIAN SUMMARY OF
JUSTIFICATION FOR REQUESTED ASSISTANCE**

Child's Name: _____ **Date of Birth:** _____

In your own words, describe your need for the requested assistance:

**STATEMENT OF SUPPORT FROM SPECIAL CHILD HEALTH SERVICES
CASE MANAGEMENT UNIT SERVICE COORDINATOR**

Child's Name: _____ **Date of Birth:** _____

Referrals to Other Sources:

	DATE	OUTCOME
() SSI	___/___/___	_____
() Medicaid	___/___/___	_____
() Medically Needy	___/___/___	_____
() Model Waiver	___/___/___	_____
() Catastrophic Illness	___/___/___	_____
() New Jersey Care Special Medicaid Project	___/___/___	_____
() Charity Care	___/___/___	_____
() Community Services (list)	___/___/___	_____
() Other _____	___/___/___	_____

Please provide a brief statement of need and clinical/social summary:

Date Application Received from Family: ___/___/___

Date mailed to NREIC office: ___/___/___

Signature of Case Manager: _____ Phone: _____ County: _____