

## **Bellows Fund Application**

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We are pleased to offer the *Bellows Fund* which helps provide AT equipment to individuals with disabilities. This program is available only through UCP affiliates.

Assistive Technology (AT) often plays a vital role in the lives of people with disabilities. AT is any item, piece of equipment, or product that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities.

Each request is reviewed on an individual basis. Requests may be granted with full payments or partial payment dependent on financial need. Financial eligibility will be established based upon tax returns and other financial records of the patient or his/her financial guarantor if necessary. Providing proof of income will be requested. Many factors are included in the decision-making process and it also depends on what funds we have available at the time of the request.

### **To Apply For Funds**

1. Complete the attached Application Form
2. Obtain a Letter of Support from a physician, therapist, psychologist, rehabilitation engineer, assistive technology professional or teacher that indicates the equipment requested is consistent with the goals and abilities of the patient. A Letter of Support Form is attached.
3. Include a copy of your quote/invoice for the equipment or technology requested.
4. Include a copy of your most recent Federal Tax Form 1040. (pg.1, showing adjusted gross income)

### **Send completed Application and required documents to:**

**Email (preferred):** [info@ucpmn.org](mailto:info@ucpmn.org)

UCP of Minnesota/Gillette Children's Specialty Healthcare  
Mail stop: 010605  
200 University Ave E  
St. Paul, MN 55101

### **Distribution of Award**

You will be notified by letter from the review board of the decision to either grant or deny funding for the equipment requested.



# Bellows Fund Application

Applicants Name

Birthdate

Address

Phone Number

City

Zip

County

Name of person completing application

Email address

Relationship to Applicant

Equipment to be purchased: Be as specific as possible, item, description, product #, supplier/vendor and cost

How will this item increase the independence or benefit the person using it

Have you had the opportunity to try this item? If so, what were the results?

Has this equipment been recommended by a professional, such as M.D., P.T., O.T. or speech therapist?

Name

Title

Phone #

Are you receiving benefits from: \_\_\_\_\_ SSI \_\_\_\_\_ SSDI \_\_\_\_\_ TEFRA

Do you have health insurance? \_\_\_\_\_ Do you receive Medical Assistance? \_\_\_\_\_

Tax return adjusted gross income? \_\_\_\_\_ Size of Family \_\_\_\_\_

(line 11 on 1040) Please attach copy

