



P.O. Box 1924
 Grand Junction, CO 81502
 Phone: 970-257-1222
 Fax 970-241-2154
 E-mail: office@coloradodiscoverability.com

Financial Assistance Application

PARTICIPANT INFORMATION:	
Today's Date:	
Name of Participant:	
Are you a Veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of Disability <input type="checkbox"/> Pre 2001 <input type="checkbox"/> Post 2001
Branch:	Rank:
Date of Birth:	
Gender:	
Address:	
City:	
State:	Zip:
Home Phone:	
Cell Phone:	
Email Address:	
Race/Ethnicity:	
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Two or More Races (Not Hispanic or Latino)	
Parent/Guardian/Person completing application:	
Relationship:	
Telephone Number:	
How long have you (participant) been with CDA? <input type="checkbox"/> New <input type="checkbox"/> Participant since (Year) _____	
Are you applying on behalf of a minor child or as the guardian of the client <input type="checkbox"/> Yes <input type="checkbox"/> No	
How did you hear about CDA?	
DISABILITY/MEDICAL INFORMATION:	
What is your (participant) disability? Please be as detailed as possible:	
<input type="checkbox"/> Neuromuscular _____ <input type="checkbox"/> Orthopedic _____ <input type="checkbox"/> Cognitive _____ <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Vision Impaired <input type="checkbox"/> Other (Please Specify) _____	
Do you (participant) use a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently in Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	

PARENT OR GUARDIAN INFORMATION:

Parent or Guardian Name:

Is the participant or parent/guardian currently employed? Yes No

Employer:

Does the client or parent/guardian receive any of the following benefits? CHECK all applicable:

Social Security SSDI Medicaid Medicare Other (Please Specify) _____

Is the participant or parent/guardian a welfare recipient? Yes No

Does the participant or parent/guardian rent or own home? Rent Own

Annual Household Income: \$

Number of people in household:

What are you able to pay?

The information above is accurate to the best of my knowledge

FINANCIAL ASSISTANCE REQUEST

Colorado Discover Ability (CDA) is a non-profit organization and has limits on funding available for assistance. We strongly encourage *participants to pay as much as they are able* so that assistance will be available to others throughout the year. Our financial assistance is now provided on a sliding scale based on income. Because we have received some grant money allocated specifically for this purpose, our funders have requested that we collect the following information from you. All of the information requested is for CDA use only and will remain confidential, unless required to be reported as part of the grant.

If there other factors that the CDA needs to consider when assessing your assistance level, please let us know below:

Amounts of CDA financial assistance awards vary based on need with an average award not exceeding 50% of the activity fee. If awarded financial assistance, the award will be extended for activities for the year applied for. A new application will be required each year beginning in December.

Please describe your reason for requesting scholarship assistance:

Thank you for your participation with Colorado Discover Ability!

We occasionally ask our scholarship recipients to write letters of support about our organization, which we use in our grant reports, marketing materials, or donation solicitations. (You can determine whether or not we use your name)

Would you be willing to write a letter of support? Yes No

I affirm that the information provided on this application is true and correct to the best of my ability. I release to Colorado Discover Ability the authority to verify the above information in the course of determining my need for financial assistance.

Name (Please Print)

Signature

Date

Colorado Discover Ability does not discriminate against employees, students, clients, or applicants for employment or services on the basis of age, ancestry, color, creed, disability, gender, national origin, race, religious beliefs, sexual orientation, or veteran status.

Office Use: Amount Approved _____ Grant _____

Approved by _____ Date _____