



1602 Rolling Hills Drive, Suite 107
Richmond, Virginia 23229
Telephone: (804) 662-7021

**NEWWELL SENSORY FUND For
Cities of Richmond, Colonial Heights, Hopewell and Petersburg and
Counties of Chesterfield, Hanover, Henrico, Goochland, Powhatan, New
Kent, Charles City, Lancaster, Northumberland, Richmond and
Westmoreland**

GENERAL REQUIREMENTS

Please read all instructions before proceeding to the application.

I. NEWWELL SENSORY FUND OVERVIEW

The NewWell Sensory Fund (Fund) is a special Virginia fund designed to help individuals of all ages with **sensory disabilities** access services in the areas noted above that cannot be funded through existing programs. Local Human Services Advocates may apply to the **“Fund of Last Resort”** for individuals needing to overcome funding or eligibility barriers. **You must demonstrate denial from all other traditional funding sources before applying to the Fund.**

If you have already purchased the equipment or service, you are not eligible to apply for this fund. This Fund is designed for the purchase of assistive technology and is not intended to pay for on-going living expenses like rent, paving driveways, building fences, tuition, maintenance of home, mortgages, medical bills and for reducing pre-existing debts.

II. The request has been facilitated and submitted by a local Human Services Advocate.

- The application must be submitted by a local Human Services Advocate, such as a case manager, rehabilitation counselor, Center for Independent Living peer counselor, social worker, occupational therapist, physical therapist, speech language pathologist, health care provider, or community provider of supported or extended employment services. A vendor or manufacturer of products or services, who might benefit by the funding of the request, cannot act as a Human Services Advocate for the purposes of this fund.

III. ELIGIBILITY CRITERIA

Consistent with the Fund’s goals, applications are encouraged for funding that meet **all** of the following criteria and will be awarded on a first come, first serve basis:

- A. The individual must have a documented hearing and/or vision loss and reside in the Cities of Richmond, Colonial Heights, Hopewell and Petersburg, and the Counties of Chesterfield, Hanover, Henrico, Goochland, Powhatan, New Kent, Lancaster, Northumberland, Richmond and Westmoreland. You must provide documentation noting your disability.**

- B. The request must be for a disability-specific service, device, or product. You must include the letter of medical necessity from your physician. The amount requested cannot exceed \$2,500.**
- C. The request meets “funding of last resort” eligibility status.**
- Applicants must show that they have thoroughly researched all governmental agencies from which they may qualify for funding or benefits. The Human Services Advocate is an excellent resource for this type of information and should be consulted to facilitate your search.
 - As a way to stretch the limited funding of the Fund, **documentation supporting that all other resources have been exhausted is required.** This documentation may be a formal letter from the organization confirming that no funding is available or it may be a list of contacts made with the dates and results of the contacts. All “pending” leads must be resolved prior to application. The applicant is strongly encouraged to explore and document community organizations for alternative funding sources. Organizations that might be considered for funding include civic organizations such as the Lions or Rotary Club or local businesses or church organizations that have community outreach programs. Friends and family are also possible sources of assistance.
 - **Financial eligibility for the “fund of last resort” will be determined by completion of the Consumer Financial Form and proof that other resources have been explored and are fully exhausted. To the degree that sufficient funding may not be available, preference will be given to requests based on severity of need, are of most benefit to the consumer, and proves to be the most cost-effective.**
- D. Because of limited funds, requests for excessively high cost or experimental medical procedures or those requests with uncertain outcomes will not be considered for funding.**
- E. If you are not awarded funding with the first submission of your application, you are eligible to reapply for the grant.**

IV. SUBMISSION PROCESS

One **original** and **2 copies** of the completed grant application and supporting documents must be received in the office of the NewWell Fund/Assistive Technology Loan Fund Authority. **The applications will be reviewed as they are received and if approved, funding will be awarded on a first come, first serve basis until all grant funding has been depleted.** Facsimiles will not be accepted or considered as received applications.

The mailing address is:

**NewWell Fund/ATLFA
Sensory Fund
Attn: Sandra Prince
1602 Rolling Hills Drive, Suite 107
Richmond, Virginia 23229**

- **Incomplete applications will be returned. We strongly encourage you to work with the local Human Services Advocate in the completion of the application.**
- All applications must be signed by the Consumer or parent/guardian.
- Applications must be **typed** or **printed** legibly or they may be returned.
- Fraudulent applications or intentional falsification of information may be investigated.



NEWWELL SENSORY FUND APPLICATION CHECKLIST

IF YOU HAVE NOT INCLUDED THE ITEMS NOTED BELOW, PLEASE DO NOT MAIL YOUR APPLICATION TO US BECAUSE IT WILL BE CONSIDERED INCOMPLETE AND RETURNED TO YOU. Please *return one copy of this checklist* with your application to ensure that you have included all the required sections.

ELIGIBILITY INFORMATION

Do you live in the Virginia cities or counties listed above and have a documented sensory disability?	Yes	No	
Did you describe in detail what your request is and why you need what you are asking for?	Yes	No	
Did you provide medical reports or assessments which confirm that what you are asking for is recommended by your physician, occupational or physical therapist, speech therapist, etc.?	Yes	No	
Did you list your efforts to locate alternative funding and exhaust all possible avenues, including applying for a loan thru the Assistive Technology Loan Fund Authority?	Yes	No	
Did you complete the Consumer's Current Financial Status form and show your contribution towards the purchase of your request?	Yes	No	

If you answered YES to all these questions, you may continue with the application. **If NO**, take corrective actions to make your response a YES.

SUBMISSION OF APPLICATION

Did you print or type the entire application?	Yes	No	
Did you provide detailed information to complete every section and did you sign the application?	Yes	No	
Did you include all the required supporting documentation?	Yes	No	
Did you include the original application and supporting documentation and 5 copies of everything?	Yes	No	

If NO, take correction actions to make your response a YES. **If you have not completed this document by answering YES to all required questions, please do not mail your application to us because your application will be returned as incomplete.** If you need assistance in filling out the application, please work with a local Human Services Advocate or contact the local Center for Independent Living in your area.



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NEWWELL SENSORY FUND

APPLICATION

Mail Completed Applications to:

(Do Not Fax – Facsimiles will not
be accepted for any reason)

NewWell Fund

**1602 Rolling Hills Drive, Suite 107
Richmond, Virginia 23229**

I. CONSUMER INFORMATION:

Applicant: _____

Address: _____

City: _____

State: Virginia _____

Zip Code: _____

Phone No. : _____

Date of Birth: _____

Date of Disability Onset: _____

Parent/Guardian: _____

II. APPLICANT'S SENSORY DISABILITY(IES): (include proof of disability)

Primary Disability: _____

Secondary Disability: _____

Additional Disability(ies): _____

III. Human Services Advocate: (such as case manager, rehabilitation counselor, Center for Independent Living peer counselor, social worker)

Advocate's Name: _____

Phone No.: _____

Organization Name: _____

Fax No.: _____

Mailing Address: _____

Email: _____

City, State, Zip: _____

IV. DESCRIPTION OF REQUEST AND BENEFIT TO THE CONSUMER

1) Please respond to all areas listed below. Requests should describe goals and consumer benefit in a manner that can be directly measured and evaluated.

(a) What equipment or device do you need? _____

(b) Is this a disability related request? Yes No If "Yes", please describe: _____

(c) Describe how this will affect your life (home, community, work)? _____

2) Please list other agencies you are currently working with: _____

V. FUNDING THROUGH OTHER SOURCES

What other funding sources have you contacted (government agencies, medical insurance, family finances, civic or community organizations). List all below and attach letters of confirmation or denial of funding, if available, or attach a list of additional contacts, if more space is needed.

VI. CONSUMER'S CURRENT FINANCIAL STATUS

CONSUMER'S CURRENT FINANCIAL STATUS

Check and detail all current sources of income and benefits of every member within the household. Please provide proof of all income, all assets, and all household monthly expenses listed on the form (i.e., checking/saving account statements, income tax return, utility payments, credit card payments, etc.). If this information is not provided then your application will be considered as incomplete and will not be processed for review.

How many individuals live in the household: _____

Household Monthly Income

Household Monthly Expenses

	Salary/Wages	\$		Rent or mortgage	\$
	SSDI			Loans	
	SSI			Auto Loans	
	Veteran's Benefits			Credit cards	
	Retirement / Pension			Other Loans	
	Worker's Compensation				
	Unemployment Comp.			Utilities	
	General Relief / TANF			Electric	
	Child Support			Water	
	Other			Gas	
				Telephone	
				Medical / Disability	
				Health Insurance	
				Doctor/Dentist visits	
				Prescription drugs	
				Personal Assistance	
				Clothing	
				Groceries	
				Transportation	
				Maintenance	
				Bus / Cab	
				Child Care	
	Medicare	<input type="checkbox"/>		Insurance	
	Medicaid	<input type="checkbox"/>		Health	
	Health insurance (specify)	<input type="checkbox"/>		Automobile	
				Home / Renter's	
				Disability	
				Other	
	Total Monthly Household Income	\$			
	Total Household Monthly Expenses	\$			
	Total money leftover after bills are paid	\$			

VII. COST OF REQUESTED SERVICES

Note: This fund will not reimburse you for items previously purchased.

SPECIFIC EQUIPMENT OR DEVICE NEEDED	AMOUNT FOR EACH ITEM
TOTAL COST OF IDENTIFIED NEEDS	

CONTRIBUTIONS TOWARDS TOTAL COST	AMOUNT OF EACH
Applicant/Family Contribution	
Other Contributions (List Amounts & Sources)	
Remaining Amount Being Requested of the Consumer Service Fund	

VIII. Please provide any additional information that may help the panel evaluate your request.

IX. I understand that the Fund may share the information in this application with the Department for the Deaf and Hard of Hearing, Department for the Blind and Vision Impaired, Hearing Loss Association of Greater Richmond, the local Center for Independent Living (CIL), Fund Review Panel, or others as necessary for the purpose of providing consumer counseling or obtaining other potential funding sources.

By signature affixed below, the undersigned certifies that all information provided within this application is accurate to the best of his/her knowledge. The undersigned understands that all information provided is subject to verification or investigation.

Date _____

Applicant Signature _____

Date _____

Parent or Guardian Signature _____

Date _____

Advocate Signature _____

Advocate Recommends:

Advocate Does Not Recommend: