United Needs & Abilities, Inc.

Enriching the lives of people with developmental disabilities

Costanzo Fund/Cash Assistance Program Request Form

Personal Information

Name of applicant:

Address of applicant:_____

Telephone: H)_____(W)_____

Social Security #:_____

Mother's Name (if applicant is a minor):_____

Father's Name(if applicant is a minor):_____

Service to be provided: _____

Reason services are needed: _____

_____

_____

Time period service covers: _____

Do you have a developmental disability with onset before age of 22 years of age? _____

Do you have epilepsy or a seizure disorder? _____

Financial Information

Individual's current annual earned income: $_____

Parent's current annual earned income: $_____

What other funding have you applied for or will you receive for the services included in this request?

_____

_____

Is there any insurance coverage? Y N If so is there a deductible that needs to be met? Y N

How much is the deductible? $_____If the deductible was met would the insurance cover the cost of this request? Y N

_____

Signature