

## **West Deerfield Township**

### **Disabilities Program**

This program is an effort to meet the unmet needs of West Deerfield Township residents in our community that are challenged with disabilities. Maximum funding of \$1,000 per year/per applicant may be awarded.

Examples of Services covered by this program may include but are not limited to:

- Durable Medical Equipment/Therapeutic/Communication Equipment
- Accessibility Equipment for Home/Car/Transport
- Outpatient Physical Therapies/Occupational Therapies/Speech Services
- Therapeutic Services
- Home Remodeling and Adaptation

Applications will be accepted throughout the year, with review and funding taking place quarterly. Applications must be received by the Township Clerk Kristen Scott by March 31, June 30, September 30, and December 31.

The Township will make payments only to third-party vendors. Each application is evaluated on its own merit.

We encourage you to apply for this program. Contact the Township office for an application: 847-945-0614 or go online to [www.westdeerfieldtownship.org](http://www.westdeerfieldtownship.org).

**West Deerfield Township  
Disabilities Program  
APPLICATION**

**Name** (applicant): \_\_\_\_\_ **Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Name of person completing this application** (if different from applicant):  
\_\_\_\_\_

**Relationship to applicant:** \_\_\_\_\_

**Address (if different from applicant):** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Funding will be used for:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Amount of funding requested:** \_\_\_\_\_

*\*Please attach pricing sheet or estimate.*

**Briefly describe disability or medical condition:** Please provide documentation from a health care professional regarding diagnosis or recommendation for item you are requesting \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please describe how this funding will be used in meeting the applicant's special needs:**

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**Please tell us a little about the applicant's household**

Number of individuals living in household of person with disabilities: \_\_\_\_\_

Total annual household income: \_\_\_\_\_

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**Please describe any special circumstances which make financial assistance for this need necessary:** \_\_\_\_\_

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Each application is evaluated on its own merit.

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Please review the below information carefully and sign where applicable.

*\*No applications will be processed without all necessary signatures and qualifying information.*

**VERIFICATION OF INFORMATION**

I stipulate that the information included in this application is true to the best of my knowledge. Further, I understand that any misrepresentation or the presence of inaccurate information in this application could result in the need for re-evaluation of this application or in West Deerfield Township's refusal to offer financial assistance.

\_\_\_\_\_

Recipient Signature or Legal Guardian \_\_\_\_\_  
Date

**RELEASE OF LIABILITY**

In consideration of the receipt of certain enabling equipment, assistive technology or services awarded by West Deerfield Township, \_\_\_\_\_ (the Recipient thereof or his/her legal guardians), hereby releases and forever discharges West Deerfield Township and its members, agents, employees and officers from and against any and all claims of any type, which arise from or are related to:

- Any alleged malfunction of or defect in the enabling equipment
- Any allegation that the funds or equipment was not appropriate or suitable for the Recipient
- Any other matter of any type, related in any way to, or arising out of, the Recipient's receipt or use of the enabling equipment, assistive technology, services or funding
- Any referral to any person, firm, corporation, governmental unit or other entity (however described) in connection with enabling equipment, assistive technology or services of any nature

\_\_\_\_\_

Recipient Signature or Legal Guardian \_\_\_\_\_  
Date

Please review the below information carefully and sign where applicable.

*\*No applications will be processed without all necessary signatures and qualifying information.*

**DISCLAIMER**

The mission of the *West Deerfield Township Disabilities Program* is to help disabled residents purchase enabling equipment and assistive technology or secure services through financial assistance. The equipment and services provided carry no warranty from West Deerfield Township. Its use, even in the event of malfunction resulting in injury, gives rise to no liability on the part of West Deerfield Township, its employees, members or officers. West Deerfield Township is in no way responsible for reclaiming, disposing of, maintaining or repairing equipment or assistive devices. It is the sole responsibility of the Recipient or legal guardian of the Recipient to maintain, repair and/or dispose of the equipment. Any other costs that may be associated with equipment or assistive devices, or any items brought about by West Deerfield Township funding (such as installation, delivery, labor, disposal, etc) that are not explicitly stated in the application and therefore part of the overall funding dollars, are the sole responsibility of the Recipient or legal guardian of the Recipient. All installation of adaptive or accessibility equipment must be in compliance with applicable building codes. West Deerfield Township is in no way responsible for ensuring compliance with any codes.

*West Deerfield Township believes information supplied in connection with this application is protected by privacy laws. No information will be disclosed unless required by the Office of the Attorney General, State of Illinois.*

I \_\_\_\_\_ am the potential Recipient or Legal Guardian of  
\_\_\_\_\_.

I have read and fully understand and agree with the above disclaimer.

\_\_\_\_\_  
Recipient Signature or Legal Guardian

\_\_\_\_\_  
Date

# **West Deerfield Township Disabilities Program**

## **APPLICATION GUIDELINES AND PROTOCOL**

- Applications are reviewed during quarterly meetings of the Disability Program Committee. Applications must be postmarked, or faxed (fax 847.945.3051), or dropped off at the Township Office by March 31, June 30, September 30, or December 31, the last calendar day of each quarter, to be considered.
- The Committee is made up of professionals in rehabilitative and special recreation services as well as parents and community members who have experience in various areas of disability and community access. All committee members serve as volunteers.
- All applications are reviewed blindly by the committee as a whole, with personal information remaining completely confidential.
- Funds will **ONLY** be paid to third-party vendors with appropriate and approved purchase order or estimate of cost.
- Funds must be used within six months of approval- and all receipts of service must be submitted.
- Maximum funding is not to exceed \$1,000 annually per household.
- Proof of West Deerfield Township residency must be attached for the applicant with this application. Examples include, but are not limited to: school registration, utility bill, or voter registration card.
- Total funds for this program may be limited by Township Board ordinances.

**If you have questions during the completion of this application, please contact West Deerfield Township at 847-945-0614 or [westdeerfield@sbcglobal.net](mailto:westdeerfield@sbcglobal.net).**