ALBERT N. SOLOMON MEMORIAL TRUST FUND 2019 GRANT APPLICATION

MUST BE POSTMARKED BY SEPTEMBER 7, 2020

> **IMPORTANT:** **Applications will not be considered unless all questions are answered.**
>
> Applicants who are awarded Solomon Trust Fund grants will be <u>reimbursed</u> for services or items that are requested on this Application. <u>A receipt must be received before a grant can be issued.</u> Do you have a plan or procedure for purchasing requested items or services, prior to receiving an award for this request?
>
> Yes ☐ No ☐
>
> If Yes, please describe the procedure.
>
> _____
>
> If the item costs more than the amount requested, how will the applicant fund the additional amount?
>
> _____

Mail completed application to:

PLAN of Massachusetts and Rhode Island, Inc.
50 Cabot Street, Suite 206
Needham, MA 02494
ATT: Lucille Cassis

A. Applicant

Name: _____Date of Birth: _____

Address: _____

City, State, Zip: _____

Type of Residential Setting: _____

B. Grant Request

Be as specific as possible about what item or service you are requesting funds for (use other side if necessary). Requests for multiple services or items (for example. clothes AND trip AND furniture) will <u>not</u> be considered.   The Solomon Trust is able to fund requests up to $300.00.

Amount of Request $_____   Item or Service Requested:

If a medical or dental item is being requested, has a request for funding this item been submitted to MassHealth? Yes ☐ No ☐

If MassHealth denied the request, what reason did the agency give for the denial?

C. What is the Financial Need for this Grant?

D. Does the applicant have a trust fund? Yes ☐ No ☐

E. Contact Information and Mailing Address for Individual Completing this Form

Name: _____

Organization: _____

Relationship to Applicant: _____

Your Address: _____

City, State, Zip: _____ Phone: _____ Email: _____

F. Mailing Address for Check if Grant Approved:

Name: _____

Organization: _____

Your Address: _____

City, State, Zip: _____

Signature: _____ Date: _____