# Marshall County Disabled Children & Adults Fund

CFOV Community Foundation for the Ohio Valley

The Marshall County Disabled Children and Adults Fund of the Community Foundation for the Ohio Valley was established in 2013 after the Marshall County Easter Seal Society disbanded. Funds will continue to be distributed to assist individuals in Marshall County with needs associated with their disability. Applicants (or the parents of applicants) must complete the application and mail it to:

Community Foundation for the Ohio Valley
1310 Market Street, Ste. 1
Wheeling, WV 26003

If funds are awarded, checks will be made payable to vendors, *not* individuals. Quotes for equipment, materials, or construction must be provided with the application.

**Maximum Request is $1,000**

Criteria of Eligibility:

- Applicant must be a resident of Marshall County
- Applicant must have a financial need and provide financial information (on application)
- Applicant must attach his/her most recent Income Tax Return
- The requested funding must fulfill a basic need that the applicant is unable to financially provide for themselves
- Applicant has exhausted all other sources of financial aid

Please print clearly and complete the entire application. Please send your completed application to the Community Foundation for the Ohio Valley. You will be notified of the status of your application after the committee meets for review and approval of requests.

For more information please call 304-242-3144 or visit www.cfov.org and follow the grants tab.

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## APPLICATION FOR FINANCIAL ASSISTANCE

### APPLICANT INFORMATION

| | | |
|---|---|---|
| Name: | | |
| Date of birth: | Home Phone: | Cell or Email: |
| Current address: | \| County: | |
| City: | State: | ZIP Code: |
| Own Rent *(Please circle)* | Monthly payment or rent: $_____ | How long at current residence?<br><br>Number of dependent children & adults in home: |

### EMPLOYMENT / INCOME / RESOURCES

| | | |
|---|---|---|
| Current employer (self and/or parents) | | |
| Applicant Employer: \| | | Salary: |
| Mother Employer: | | Salary: |
| Father Employer: | | Salary: |
| Other Income:<br>(SS, SSI, SSDI)<br><br>Please list resources you have explored for this request: | Source: Amount:<br><br>Source: Amount:<br><br>Resources Explored: | Annual Household Income:<br><br>Please circle which supports you currently receive:<br><br>Waiver<br>Energy/Utility Assistance<br>Medicaid<br>Medicare<br>Private Insurance<br>SNAP<br>WIC<br>Other: |

### REQUEST FOR SERVICES & SUPPORT ***MAXIMUM AMOUNT AWARDED IS $1,000*** EACH 12 MONTHS

| | |
|---|---|
| What is your disability: | |
| Have you requested assistance through this source in the past? YES NO<br><br>What is the amount of your request? $_____<br><br>What services/support are you requesting: | Please attach estimates for your request<br><br>You may utilize the back side of this application for any additional information supporting your request |

### SIGNATURES

If you are completing this application for someone, please provide your contact information:

Name: _____ Relationship to Applicant: _____

Phone: _____

Email: _____

| | |
|---|---|
| Signature of applicant: | Date: |
| Signature of person completing application (for applicant) | Date: |