

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  
1226 Chapline Street  
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](http://www.cfov.org) and follow the grants tab.

## APPLICATION FOR FINANCIAL ASSISTANCE

### APPLICANT INFORMATION

Name:		
Date of birth:	Home Phone:	Cell or Email:
Current address:		County:
City:	State:	ZIP Code:
Own    Rent <i>(Please circle)</i>	Monthly payment or rent: \$ _____	How long at current residence? 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: (SS, SSI, SSDI)	Source:                      Amount:	Annual Household Income:
	Source:                      Amount:	
Please list resources you have explored for this request:	Resources Explored:	
		Please circle which supports you currently receive: Waiver Energy/Utility Assistance Medicaid Medicare Private Insurance SNAP WIC 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	Please attach estimates for your request  You may utilize the back side of this application for any additional information supporting your request
What is the amount of your request? \$ _____	
What services/support are you requesting:	

### 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: