

Mini-Grants for Services and Items Instructions for Completion

Who Qualifies:

To receive Mini-Grant funding the person must have one or more of the following diagnoses.

An Alaskan diagnosed with ADRD (Alzheimer's disease and related disorders: including Parkinson's Dementia, Multi-Infarct Dementia (stroke-related), Pick's Disease, Lewy Body Dementia, Huntington's Disease or Creutzfeldt-Jakob Disease).

Application Criteria

Provide to individuals diagnosed with ADRD:

- Essential items which will directly improve their quality of life and increase their independent functioning.
- Medical, dental, vision, hearing, supplies, therapeutic devices, adaptive equipment, and accessibility improvements.
- No other funding source is available for item or service. No existing bills.

Review Application Checklist

1. The beneficiary or the beneficiary's family member, care coordinator, legal guardian, power of attorney or another person can apply.
- 2. If applicable, the signature of legal guardian or power of attorney is needed.**
3. All information must be completed on form; incomplete applications will be returned.
4. Attach a written estimate from vendor (store, provider or supplier) to be used. If applicable add shipping, handling and/or installation charges.
5. Verify that person requesting grant has one of the qualified diagnoses listed above. If available attach supporting documentation of diagnosis.
6. Verify the physical address of person on application form.
7. Please note the maximum Mini-Grant request is \$2,500; however an applicant may submit more than one application per year, as long as the combined applications do not exceed \$2,500.
8. Mail or Fax application to: Alzheimer's Disease Resource Agency of Alaska

1750 Abbott Road
Anchorage, AK 99507
Telephone (907) 561-3313/Fax (907) 561-3315

How grant works:

Submit a completed Mini-Grant application with an estimate from the vendor to be used for the item/service requested. Application will not be processed until all information is completed. Completed applications are considered for funding based on level of need and date order. Once a grant is awarded a Purchase Order (PO) is sent directly to vendor. **Do not pay for item/service out of pocket. Grant will not pay for item/service if purchased or received by applicant prior to grant approval.** A check for payment is sent to vendor after an invoice for completed item or service is sent to Alzheimer's Disease Resource Agency. **Process may take 3-6 months for review. Please do not inquire into the status of grant; a letter will be mailed to applicant.**





ALZHEIMER'S RESOURCE AGENCY OF ALASKA
 1750 Abbott Road, Anchorage, AK 99507
 Phone (907) 561-3313 Toll-Free within Alaska (800) 478-1080
 www.alzaska.org Fax (907) 561-3315

MINI-GRANT APPLICATION

IMPORTANT NOTE: *If this Mini-Grant is approved, payment will be made directly from the Alzheimer's Resource Agency of Alaska to the vendor for the items or services purchased for the Beneficiary. You will be contacted by the Outreach Program staff. Please complete all information. Attach a copy of the written estimate for the items or services needed.*

<p align="center">Person filling out this application</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ Zip _____</p> <p>Day Phone _____</p> <p>Evening Phone _____</p> <p>E-mail _____</p> <p>Fax _____</p> <p>Relationship to Beneficiary _____</p>	<p align="center">Person who will receive the services or items from this grant</p> <p>Name _____</p> <p>Circle Dementia Diagnosis: Alzheimer's Parkinson's Stroke-related Pick's Disease Lewy Body Huntington's Cruetzfeldt-Jakob Disease</p> <p>Social Security Number _____</p> <p>Date of Birth _____ Age _____</p> <p>Gender (Circle one) Male Female</p> <p>Ethnic Background (Circle one) Native Alaskan/Native American Hispanic Caucasian (Non-Hispanic) Black Asian/Pacific Islander Other _____</p> <p>Beneficiary Coverage (Circle yes or no for all options) Medicaid Y N Medicare Y N Choice Medicaid Waiver Y N Other Insurance _____</p>
<p>PHYSICAL ADDRESS OF PERSON TO RECEIVE GRANT <i>(For delivery of items or services)</i></p> <p>Address _____</p> <p>City _____ Zip _____</p> <p>Name of Facility/ALH if applicable _____</p>	

Amount of Mini-Grant Request: _____ (Maximum \$2,500)

Specific Item(s) or services to be purchased with this Mini-Grant _____

Explain how this Mini-Grant will allow Beneficiary to receive an essential item, how the item will increase independent functioning, and how it will improve the Beneficiary's quality of life:

Store or supplier (Vendor) from which the item(s) or service(s) will be purchased:

Name of Store or Supplier _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Contact Person** _____

***This Mini-Grant Application Must be Signed in order to be processed
 Please Review Application Checklist on otherside***

I certify that the information submitted in this form is true and accurate to the best of my knowledge. It is my understanding that the items or services for which I've requested this Mini-Grant are not covered by any other funding source.

Signature of Person filling out application _____ Date _____

Signature of Person to receive grant or legal guardian or Power of Attorney _____ Date _____