Adler's Voice
Grant Application

Adler's Voice Grant Program
PO Box 6344
Bend, Oregon 97708
541-408-1092
stephanie@adlersvoice.org

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Thank you for your interest in the Adler's Voice Grant Program. Adler's Voice will provide assistance to individuals ages birth to 21 residing in Oregon that experience a complex communication disorder, so that they may access the tools they need to communicate to the best of their abilities. It is our belief that the ability to communicate in any way opens doors for all individuals.

Adler's Voice provides Augmentative and Alternative Communication Devices and funding for services, such as speech therapy sessions and sign language courses, to individuals with complex communication disorders. Applications requesting Assistive Technology for educational purposes will not be considered.

Please complete the following application form and mail it to the address listed above, or send it by email to stephanie@adlersvoice.org. Since incomplete or unsigned applications cannot be reviewed, please take the time to fill in all fields and sign the form after completion. If an iPad is being requested, please make sure to read the iPad Agreement at the end of the application form. In order to fulfill the requirements for a successful application, you will also have to attach the following documents:

1. Income verification (for instance, pay stubs, social security award letters, current bank statements with direct deposit, and the like) covering the 30 days that precede the application
2. Copies of most recent IEP and/or speech evaluation
3. A written recommendation for the equipment or service being requested from a physician, physical therapist, speech language pathologist, occupational therapist or educator
4. Signed Authorization to Release Healthcare Information

For your convenience, forms have been provided for (3) and (4). Applications will be reviewed between 30 to 45 days from date of receipt. Those applications that have been approved will be notified by phone. Incomplete or ineligible applications will be notified by mail.

A. Personal Information

In order to contact you and to evaluate your request, we would need some information about yourself and the individual who will benefit from the grant. Please begin by telling us about yourself.

Your Name _____

Your Address _____

_____

Your Phone Number(s) _____ (Home)

_____ (Work, if applicable)

_____ (Mobile, if applicable)

Your Email Address _____

Please tell us about the individual for whom you are requesting assistance. For purposes of this application, this person will be referred to as "Applicant."

Name of the Applicant _____

Date of Birth _____ MM | DD | YYYY

Gender

- ☐ Male
- ☐ Female

Ethnicity (optional)

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Hispanic / Latino
- ☐ White
- ☐ _____
- ☐ More than one ethnicity
- ☐ I prefer not to answer.

If you are applying for someone else, the applicant is

- ☐ your child
- ☐ your grandchild
- ☐ your foster child
- ☐ your student
- ☐ _____

A. Personal Information (Cont.)

Please tell us about all of the people living in the applicant's house, related and unrelated, and provide some basic information about the household income. If you need additional space to list members of the household, please use the back of the page. As mentioned on the first page of this application form, please make sure to provide copies of pay stubs and eligibility or benefit statements.

Names of Adults in the Household and their Relationship to the Applicant

Names of Children in the Household and their Relationship to the Applicant

Gross Monthly Earnings for all Adults Living in the Household

.00 $ →

Public Assistance, if applicable

- ☐ Oregon Health Plan →
- ☐ TANF .00 $
- ☐ SSI .00 $
- ☐ SNAP .00 $
- ☐ _____

B. Communication Needs of the Applicant

Please tell us how the applicant currently communicates and what methods of communication the applicant uses. In order to evaluate this application for assistance, it is important for us to understand where the applicant is currently with their communication needs.

Medical Diagnosis of the Applicant

How would you describe the applicant's current level of expressive communication?

If the applicant is non-verbal, how is (s)he communicating? Check all that apply.

- ☐ Sign Language
- ☐ PECS
- ☐ PODD
- ☐ iPad
- ☐ Other High Tech Device(s)
- ☐ Gestures / Pointing
- ☐ Vocalizations
- ☐ Eye-Gaze
- ☐ _____

The next four questions can be skipped if the applicant does not use an iPad for communication purposes.

If the applicant is using an iPad for communication, which AAC apps have they used on this device?

B. Communication Needs (Cont.)

How proficient is the applicant in using the iPad? Check all that apply.

- ☐ Independent
- ☐ Needs adult assistance to get applications set up
- ☐ Needs adult monitoring to stay in the same application
- ☐ Needs constant assistance
- ☐ Can transport the device safely from one environment to another

How proficient are you in using the iPad?

☐ Very ☐ Somewhat ☐ Not at all

How proficient are you in modelling communication on the iPad?

☐ Very ☐ Somewhat ☐ Not at all

Please tell us who provides Speech Language Pathology (SLP) and Augmentative and Alternative Communication (AAC) services and supports to the applicant in both the school setting and, if applicable, private practice. We may need to contact these individuals if we have questions concerning the applicant's communication needs, so that we can best understand how we may be able to help.

Life Skills Teacher _____

School District _____

Address _____

_____

Phone Number _____

Email Address _____

B. Communication Needs (Cont.)

School or ESD SLP

Agency

Address

Phone Number

Email Address

AAC Specialist

Agency

Address

Phone Number

Email Address

Private Practice SLP, if applicable

Clinic

Address

Phone Number

Email Address

C. How Can We Help?

Please tell us more about the nature of your request. If you are requesting assistive technology, please provide information on how the applicant will use the technology. This will help us determine if any additional support will be necessary in order for the device to be used successfully by the applicant.

What equipment, devices, applications, or services are you requesting for the applicant?

If you request assistive technology, how will the requested technology be used at home?

Do you anticipate any barriers to using the requested technology at home? Please describe.

Will the requested technology be used at school? And if so, how?

C. How Can We Help? (Cont.)

Will the use of the requested technology be supported by the IEP team of the applicant?

☐ Yes ☐ No

Has the applicant had a trial period with the requested technology? If so, please describe.

D. Declaration

I have attached the following required documents:

☐ Income Verification

☐ IEP and/or Speech Evaluation

☐ Completed and Signed Referral from Specialist

☐ Signed Authorization to Release Healthcare Information

I certify that the foregoing information is true and accurate to the best of my knowledge. If an iPad is being requested, I hereby acknowledge that I have read, understood and agree to the terms of the iPad Agreement below (section E, page 9).

Date

Signature ✗

E. iPad Agreement

By submitting an application to the Adler's Voice Grant Program that includes a request for an iPad, Applicant (or, if applicant is a minor child, Applicant's parent/guardian, for the purposes of this agreement only hereinafter collectively referred to as "Applicant") acknowledges and agrees to the following:

1. Adler's Voice is providing the iPad to Applicant with the understanding that the iPad will be used solely by and for the benefit of the Applicant for the purpose of facilitating, augmenting, and/or improving communication. In accordance with best practice recommendations, the iPad shall not be used for any other purpose.
2. Therefore, Applicant understands and agrees that the iPad will be "locked out" from the ability to install any additional applications, other than the AAC application that will be provided by Adler's Voice, such that the iPad will become a dedicated communication device.
3. Adler's Voice will provide with each iPad the specific AAC app requested in the grant application.
4. Should Applicant's grant be approved, upon acceptance of the iPad, Applicant accepts full ownership of the device, and agrees to be responsible, at Applicant's expense, for any repairs that Applicant determines are reasonably necessary to allow the continued use of the device by Applicant's Child.
5. Once Applicant accepts delivery of the device, Adler's Voice is not responsible for any costs associated with the device, including repair or replacement. Applicant agrees to assume full financial responsibility for the repair or replacement of the iPad and any accessories provided by Adler's Voice.
6. Applicant agrees to send the iPad to school with the recipient on a daily basis; to use the device to the extent reasonably possible in private therapy settings; and to use Applicant's reasonable best efforts to incorporate the device into the daily life of the recipient.
7. Applicant agrees to participate in a series of 3 to 4 trainings on the implementation on of AAC devices, provided at no cost by Adler's Voice. Additionally, Applicant agrees to provide progress reports on the Applicant's use of the iPad at 1 month, 6 month and 12 month intervals from the date the Applicant receives the iPad, to share successes and challenges, and to provide recommendations and suggestions on how Adler's Voice might improve its programs.

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HIPAA Privacy Authorization to Release Healthcare Information

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Name _____ DOB _____ Social Security # _____

I authorize the individuals/agencies/organizations marked below to release and share protected health information of the above-identified individual to Adler's Voice for the purpose of evaluating individual's grant application.

☐ School District: _____ ☐ ESD: _____

☐ Other: _____ ☐ Other: _____

☐ Other: _____ ☐ Other: _____

I understand and agree that the type of information marked below may be disclosed/exchanged (initial all that apply):

_____ Assessment(s)
_____ Progress Notes
_____ Therapy Plan and Notes
_____ Case Management Plan
_____ Med. Management Notes/Medication Log
_____ Psychological Testing
_____ DD Eligibility Statement
_____ Individual Education Plans (IEPs)
_____ Cognitive and Adaptive Evaluations
_____ Individual Service Plans
_____ Diagnosis and Recommendations
_____ Individual and Family Support Plans
_____ Other: _____
_____ Other: _____

I understand and agree that the following types of information may also be disclosed/exchanged, but ONLY if I place my initials in the space next to the information:

_____ Psychiatric/Mental Health Records
_____ Genetic Testing Information
_____ HIV/AIDS
_____ Alcohol/Drug Diagnosis, Treatment, Referral

I understand that this authorization is valid for one year, unless otherwise specified. I understand that I have the right to revoke this authorization, in writing, at any time. Such cancellation does not affect any information that was already disclosed. I understand that I may refuse to sign this form.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law, EXCEPT THAT redisclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by state or federal law.

I understand that my personal health information is confidential and may be protected by state and federal laws, and I approve the release of my personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form.

Date _____

Signature ✗ _____

Signator's Relationship to Individual ☐ Self ☐ Parent ☐ Guardian* ☐ Legal Custodian*

* Guardianship/custody documentation in file/provided per request

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Referral Form

Your physician or therapist may send in their own referral form if preferred. All the fields in the Referral Source section must be included for the application to be considered complete.

Referral Source

Date of Referral _____

Physician or Therapist Name _____

Address _____

_____

Phone Number _____

Fax Number _____

Email Address _____

Patient Details

Patient Name _____

Diagnosis _____

Technology or Services Being Requested

Please provide specific details about the patient's communication needs and their current level of communication.

_____

_____

_____

_____

_____

_____

Physician or Therapist Signature _____ ✗