2018 Personal Care Attendant Stipend Program
PRELIMINARY APPROVAL APPLICATION

PERSONAL CONTACT INFORMATION	
Name	
Address	
City, State, Zip	
Phone	
E-mail	
Have you received a diagnosis of LGMD or other form of Muscular Dystrophy, confirmed by genetic testing? Please list your diagnosis.	
*Deadline for submission of preliminary applications is December 10th. The Speak Foundation will consider each preliminary application (applications will be reviewed by medical professionals as well as The Speak Foundation's board members) and notify the approved recipients to file a formal application. Those in greatest need will be given priority, as slots for this program are limited. The endowment for this program has a request that LGMD patients be considered first; however, we encourage all to complete this preliminary application, regardless of form of muscular dystrophy or income level. *All information provided on this application is confidential.*	

ELIGIBILITY CRITERIA	
Please mark the following with an X and include remarks in the comments section where necessary/requested: 1. Do you live alone? Yes ___ No ___ 2. Are you single ___ engaged ____ married ____ divorced ____ 3. Do you have children? Yes ___ No ___ (if so, please list ages of children) 4. Do you use a wheelchair or scooter 80% of the day outside of your home/at work? Yes ___ No ___ (please include when you began to use a wheelchair/scooter at work).	Comments:
5. How many hours a week do you work outside of your home? 6. What are your daily work hours? (ex. 9 am to 5 pm)	Comments:
The parameters of this grant specify that individuals must require help to perform the tasks listed below. For each task that you require assistance with, please provide additional information in the comments section (regarding the kind of assistance you require, etc). 7. Do you require help with bathing? Yes ___ No ___ 8. Are you able to get dressed independently? Yes ___ No ___ 9. Are you able to get out of bed independently? Yes ___ No ___ 10. Are you able to toilet independently? Yes ___ No ___ (if you have difficulty toileting, describe accommodations at work)	Comments:

11. What durable medical equipment (DME) do you currently use (such as cane, hospital bed, cough assist, wheelchair, etc.)? 12. Do you drive a wheelchair adapted van? Yes ___ No ___ 13. Do you currently receive supplemental security disability income (SSDI) or social security income (SSI)? 14. Do you currently receive funding via personal care waiver programs (such as Medicaid, etc.)? If so, please explain. 15. What is your gross yearly income and net income? (W2 forms will be required with formal applications) 16. If married, what is your combined income before taxes and after taxes? (W2 forms will be required with formal applications)	Comments:

*Feel free to include any other information that you feel may be pertinent in the space below, including any special circumstances you may have: