



QUALITY OF LIFE GRANT APPLICATION

NAME: _____

DATE: _____

ADDRESS: _____

CITY: _____ STATE/PROVINCE: _____ ZIP CODE: _____

PHONE NUMBER: _____ ALTERNATE NUMBER: _____

E-MAIL ADDRESS: _____

DOB (MM/DD/YYYY): _____ GENDER: _____

DATE OF INJURY: _____ LEVEL OF INJURY: _____

CAUSE OF INJURY: _____

ARE YOU WORKING WITH A SOCIAL WORKER? _____

HOW DID YOU HEAR ABOUT THE SSA GRANT APPLICATION? _____

DESCRIBE THE DEGREE OF YOUR DISABILITY AND HOW IT AFFECTS YOUR EVERYDAY LIFE: _____

DESCRIBE YOUR SOURCES OF FINANCIAL SUPPORT (DOCUMENTATION MAY BE REQUESTED): _____

FACTORS YOU WISH TO BE TAKEN INTO CONSIDERATION (HEALTH FACTORS, LIVING ARRANGEMENTS, FINANCIAL ISSUES, FAMILY ISSUES, ETC): _____

PLEASE GIVE A DETAILED DESCRIPTION OF THE EQUIPMENT OR MODIFICATIONS FOR WHICH YOU ARE APPLYING, INCLUDING MANUFACTURER'S NAME, MODEL NUMBERS, ETC. IF APPLICABLE: _____

PLEASE GIVE A BRIEF EXPLANATION OF HOW THE EQUIPMENT OR MODIFICATIONS FOR WHICH YOU ARE APPLYING WOULD IMPACT YOUR DAILY LIFE: _____

ADDITIONAL COMMENTS: _____

IN ORDER TO BE CONSIDERED FOR AN SSA INDIVIDUAL GRANT, APPLICANTS MUST PROVIDE ESTIMATES FOR THE COST OF THE EQUIPMENT OR RENOVATIONS REQUESTED. *INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.*

PLEASE PROVIDE THE NAMES, ADDRESSES AND PHONE NUMBERS OF AT LEAST TWO (2) COMPANIES AND/OR CONTRACTORS YOU HAVE CONTACTED AND THEIR ESTIMATES FOR THE EQUIPMENT OR MODIFICATIONS REQUESTED. PLEASE ATTACH ANY WRITTEN QUOTES, IF ANY, THAT YOU HAVE RECEIVED:

COMPANY AND CONTACT NAME: _____

ADDRESS: _____

CITY: _____ STATE/PROVINCE: _____ ZIP CODE: _____

PHONE: _____ WEB ADDRESS (IF ANY): _____

PRICE QUOTED: _____

COMPANY AND CONTACT NAME: _____

ADDRESS: _____

CITY: _____ STATE/PROVINCE: _____ ZIP CODE: _____

PHONE: _____ WEB ADDRESS (IF ANY): _____

PRICE QUOTED: _____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE AND ABILITY, THE INFORMATION INCLUDED IN THIS APPLICATION IS ACCURATE AS OF THE DATE SIGNED BELOW. I ALSO ACKNOWLEDGE THAT I AM AWARE THAT IF I RECEIVE AN SSA GRANT, MY NAME/IMAGE MAY BE USED BY SSA FOR MEDIA AND/OR PROMOTIONAL PURPOSES.

SIGNATURE: _____

DATE: _____

MAIL APPLICATION TO:
SYRACUSE SPINAL ASSOCIATION
1801 MILTON AVE
P.O BOX 236
SYRACUSE, NY 13209