The Special Needs Fund:
The Southern New Jersey Regional Early Intervention Collaborative

Purpose:

The purpose of the Special Needs Fund is to provide assistance to families of infants and toddlers under with disabilities under the age of three impacted by the high costs of supports/services not covered through Part C, medical insurance, MEDICAID, or other widely available funding sources.

The assistance contemplated by this Fund is limited to eligible services and equipment, as defined below.

Eligibility Criteria:

1. Applicant must be a resident of and receive Part C early intervention services in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester or Salem counties, New Jersey.

2. Applicant must be the primary legal caregiver(s) for the infant or toddler.

3. Applicant must have a signed Individualized Family Service Plan (IFSP) in which the requested service(s) or device(s) are:

    a. Related to the stated outcomes; or

    b. Identified on the IFSP service pages.

4. Applicant must complete and sign the full application and submit it with the following attachments:

    a. Written documentation showing denial of assistance from other agencies or charities for the expense. This may be shown by providing dated copies of bills, invoices or receipts along with statement(s) of partial payment/rejection of benefits from insurance, MEDICAID, or other funding sources;

    b. Alternatively, if an applicant is unable to provide written documentation from other agencies or charities as contemplated by (a) above, applicant may submit a detailed statement detailing: (1) which agencies to which he/she has applied along with the address, phone number and contact person; (2) the date upon which the applicant was denied assistance; (3) the reason that the applicant was given for the denial;

    c. A letter written by the parent/caretaker stating why they are requesting assistance for the Special Needs Fund;

d. A letter of support from the child's Special Child Health Services Case Management Unit Service Coordinator or other representative of the Part C Early Intervention Program;

e. A copy of the current IFSP; and

f. Written proof of the cost of the service(s) or device(s) for which the applicant seeks funds.

Eligible Services and Equipment:

Eligible services and equipment are limited to the following:

1. Community Activities/Programs as identified or relate to the goals stated in the ISFP. For example, swimming classes, recreation programs, social skills classes, therapeutic horseback riding programs, on the condition that these are related to or will assist in furthering the goals outlined in the IFSP.

2. Adaptive/Assistive Devices/Orthopedic Equipment: For example: Any item, piece of equipment, or toy that is used to increase, maintain, or improve the functional capabilities of children with disabilities. Special requirements for devices of equipment:

    a. A statement of need signed by a physician or medical professional must be attached to the application (except for adaptive toys).

    b. If the funds requested will only partially support the purchase of the device or equipment, an explanation of how the remaining balance will be paid (such as, time payments, personal loan, other foundations, or community fundraising, etc.).

3. Respite/Child Care Services: Definition – child care or respite services to help meet the needs of the family and primary care providers.

4. Conferences: Definition – Conference or Workshop registration for the applicant related to the child's special need/diagnosis.

Time Lines for Submission of Awards of Assistance:

1. Expenses submitted may not be more than 1 year old as of the date of submission of the application.

2. Applications should be mailed to :
   The Special Needs Fund
   SNJREIC
   339 North Rt. 73
   Berlin, NJ 08009

Decision Process for Assistance:

Decisions on the provision of assistance will be made by the SNJREIC Board of Trustees, which will review each application and will base decisions on both family income and child/family needs.

The Board of Trustees will decide on the request for assistance by voting at the next scheduled meeting.

The Board of Trustees has the full discretion to deny, grant, or award assistance for each request in whole or in part.

Urgent Request for Assistance:

If the request for assistance is urgent then the Chair of the Board of Trustees may call a vote by notifying the entire Board of Trustees via electronic communications or phone. A minimal of three Board of Trustees members including the Chair will constitute a voting quorum for urgent assistance. Any Board of Trustees member not responding to electronic communication or phone to cast a vote within 48 hours will be tallied as absent from the vote. The Chair of the Board of Trustees will e-mail the fully disclosed results to the entire Board of Trustees by the 4th day after the call for the urgent assistance vote.

Assistance will not exceed FIVE HUNDRED DOLLARS ($500) per family, per rolling year and will be based on availability of financial resources within the SNJREIC Special Needs Assistance Fund. The Board of Trustees may increase this amount, if they find that unique circumstances so warrant, at the complete discretion of the Board of Trustees.

All information provided will be confidential and will only be used for the purpose of determining need and financial award.

Members of the Board of Trustees and employees of SJREIC are not eligible to apply.

THE SPECIAL NEEDS ASSISTANCE FUND IS SUPPORTED SOLELY BY PRIVATE DONATIONS AND IS NOT PART OF THE NEW JERSEY'S STATE-FUNDED EARLY INTERVENTION PROGRAM.

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APPLICATION

Child's Name:	Date of Birth:
Diagnosis or Area of Developmental Delay:	Name of Service Coordinator:
Date of Most Recent IFSP:	Have you previously submitted an application? ____Yes ____NO If yes, Date:_____ Amount Received:_____
Amount of current request:	Why are funds being requested?
List all other attempts to secure funding:	

PARENT/CARETAKER INFORMATION

Name:	
Address:	
Phone (Home):	Phone (Work):

Name:	
Address:	
Phone (Home):	Phone (Work) :

CURRENT EMPLOYMENT INFORMATION

Principal Place of Employment:	
Address:	
Occupation:	
Status:	( ) Full-time ( ) Part-time
Family's Gross Income: (yearly)	
Family Size:	

Principal Place of Employment:	
Address:	
Occupation:	
Status:	( ) Full-time ( ) Part-time
Family's Gross Income: (yearly)	
Family Size:	

ADDITIONAL INCOME

Please list any additional income or assistance your family currently receives from any source:

Amount:	
Source:	
Frequency:	

PARENT/GUARDIAN SUMMARY OF JUSTIFICATION FOR REQUESTED ASSISTANCE

CHILD'S NAME: _____DATE OF BIRTH: _____

In your own words, describe your need for the requested assistance. Please include your financial needs, as well as your child/family needs and any issues or special conditions which influence your request. Indicate family size and age of all children living in the household.

You must include the following:

A. ( ) Written documentation showing denial of assistance from other agencies or charities for the expense. This may be shown by providing dated copies of bills, invoices or receipts; statement(s) of partial payment or rejection of benefits from insurance, MEDICAID, and/or other funding sources.

Note: if you are unable to provide written documentation from other agencies or charities, you may instead attach a detailed statement detailing: (1) the agencies to which you have applied along with the address, telephone number and contact person; (2) the date upon which you were denied assistance; (3) the reason that you were given for the denial.

B. ( ) A letter of support from the child's Service Coordinator or other representative of the Part C Early Intervention Program.

C. ( ) Copy of current IFSP (Individual Family Service Plan)

D. ( ) Written proof of the cost of the service(s) or device(s) for which you are seeking funds.

E. ( ) A statement of need signed by a physician or medical professions (for adaptive/assistive devices/orthopedic equipment only).

I certify that:

1. These expenses are related to the needs of my child as identified on his/her IFSP.
2. These expenses were not paid by any other source.
3. All the information contained in this application is accurate/true.
4. The financial assistance will be used for the approved purposes.
5. I understand that the final determination will be made at the sole discretion of the SNJREIC.

_____ _____

Signature of Applicant(s) Date

_____ _____

Signature of Applicant Date