The Atlantic Center for Independent Living, Inc. has received funding to support individuals with disabilities residing in Atlantic County, New Jersey. The program is intended to provide assistance to individuals to overcome barriers in their lives that arose, as a result of the pandemic.

Submission of this Application is the First step toward gaining the funding to help regain your complete independence.

Please visit [www.atlanticCil.org](http://www.atlanticCil.org) for more information about documentation required

CARES ACT 2020

Request for Relief Funding



|  |
| --- |
| Consumer Information  |
| Name: Click to Enter First and Last Name |
| Address: Click to Enter First and Last Name |
| City: Click here to enter City | Zip Code: Click to enter Zip Code | County: Atlantic | State: NJ |
| Phone Number: Click here to enter Phone Number |
| Email: Click here to enter Phone Number |
| Birthdate: Click enter Birthdate (Format mm/dd/yyyy)  |
| Disability Type Choose from Drop down Menu:  |
| Request Type Choose from drop down menu |
| [ ]  Is this a Necessity? [ ]  Is it CoVID-19 Related [ ]  Did you already Purchase the item?  |

Describe the request in detail showing need, how it is related to CoVID-19 pandemic and cost of request. Include information regarding any other financial assistance you have received to support this need.

Click here to enter text.

Describe your desired goal or outcome from the request.

Click here to enter text.

Please choose one option below:

Choosing either option will not change the services and support AtlanticCIL will provide, it is simply to define whether you would like these plans in writing or not. Regardless of my choice I understand that I have the right to change my mind at any time. I understand all my information is and will remain confidential.

[ ]  YES, I would want my Independent Living Plan in writing

[ ]  NO, I do not want an Independent Living Plan in writing

I, **Click to enter Full Name**  residing in the County of Atlantic agree that the information provided in this application is true and accurate. I agree this request is for myself, that it is a reasonable necessity as a result of the CoVID-19 pandemic.

Enter Full Name Click to enter today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Is your Application Complete?

Save Copy of Application and attach to email addresses to jburke@atalnticcil.org

Office Use Only

 Approved

 Denied Reason for Denial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recommendations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_

Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Atlantic Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_