

SCI SPECIAL FUND

A NON-PROFIT INCORPORATED FOUNDATION

I.D. #33-0310017

Rogers A. Severson
President

Dear Potential SCI Recipient,

The SCI Special Fund is pleased that you are interested in applying to our organization. ***The Mission of the SCI Special Fund is to assist individuals with spinal cord injuries maximize their independence through life changing activities.*** Examples may include but are not limited to the following:

- Assistance with physical therapy or other medically related procedures
- Assistive technology
- Equipment
- Transportation
- Education
- Employment

Attached you will find an Application Packet which includes:

- General overview of the SCI Fund
- Application / Biographical Information Request Form
- Verification of Disability Form (*must be filled out by your Doctor*)

Please provide the requested information and include a letter explaining why you need funding. Once this information is received you will be contacted to arrange an interview. SCI Special Fund cannot commit to funding. Each request is evaluated independently based on need and overall ability to benefit from the services requested. Also be aware that awards are on a one-time-only basis, and once a need has been assessed and paid for, no other costs or services can or will be allowed*.

Recipients are typically awarded on one or more of the following factors:

- A persistent spinal cord injury or central nervous system disease
- The ability to effectively change their lives by this award
- Personal recommendations

NOTE: you must be a citizen or documented alien to receive services from this fund. Proof may be required.

Please return the completed information to:

**Nancy A. Quarles
C/O SCI Special Fund
30398 Esperanza
Rancho Santa Margarita, CA. 92688**

Or fax to 714-480-3303, attn: Nancy Quarles

We look forward to hearing from you!

** No-interest loans may occasionally be considered where there is a reliable source for repayment.*

Application / Biographical Information

All information will be considered strictly confidential for the use of the SCI Special Fund only.
Awards are made without regard to the applicant's race, creed, national origin, gender, age, or disability.

() Mr. () Ms. _____
Last Name First Name M.I.

Street Address: _____
Number and Street Apt./Unit #

City, State, Zip: _____

Phone: _____
Home Work email address

Birthdate: ____ Age: ____ Gender: ____ Male ____ Female
mm dd yyyy

Marital Status: __ Single __ Marr. __ Separated Do you live with your parents? ____
Y N

Are you a single parent? ____ Number of dependents: ____
Y N

Are you working? ____ If yes, where? _____
Y N

How many hours per week? ____ Supervisor's name: _____

Company address/phone number _____

Do you have a disability? ____ If yes, please describe: _____
Y N

What are your career goals? _____

What are your educational goals? _____

Are you a veteran or a child of a veteran? ____
Y N

Have you received any awards or honors? ____ If yes, please describe: _____
Y N

What is your annual income? ¹ \$ _____ What is your parent's annual income?²
\$ _____

Describe what your need is and why. _____

How much do you think your project/need will cost? \$ _____

¹ Please provide Adjusted Gross Income from the previous year filed.

² Please provide Adjusted Gross Income from the previous year filed.

**SCI Special Fund
Medical Verification of Disability**

The individual below may be eligible for special consideration from the SCI Special Fund.

Name of potential recipient _____
Last name First name MI
Birthdate (mm/dd/yyyy) _____ Social Security # _____

[I authorize you to release from your records any information regarding my medical and/or health conditions to the SCI Special Fund. All records maintained by the SCI Special Fund personnel pertaining to the named potential recipient are protected from disclosure and are subject to all other requirements of confidentiality. Participation with the SCI Special Fund is entirely voluntary; however, these records will be held in confidentiality at the SCI Special Fund office and may be retrieved only by the named potential recipient after signing a release form.]

Signature of potential recipient _____ Date _____

Please name the Physician, Specialist or Agency who can provide verification of your disability

Name _____

Title/Professional designation _____

Address, City, State, Zip _____

Phone # _____ email address _____

To the Physician/Specialist/Agency:

Please check all of the following that apply to the potential recipient's disability. It would also be beneficial if you would list the degree, progressive factors involved, and/or any limiting effects of the disability. Such documentation may be provided in the space below or by forwarding tests or other verification.

____ Mobility ____ (corrected) Visual Acuity ____ left ____ right ____ speech
____ ABI ____ (corrected) Hearing db ____ left ____ right ____ DDL
____ LD ____ Other Health (please explain) _____

Progressive Factor(s) _____

Medication _____

Side Effects _____

Diagnosis _____

Description of Functional Limitation _____

Signature of Physician/Specialist Title/Position License #