

### BERGEN SAIL APPLICATION

Welcome to the (SAIL) Program Administered by Heightened Independence and Progress, a Center for Independent Living (hipcil).

In order for us to be more efficient in evaluating your request for funding

**We will not be able to process your request, until all documents are received.**

#### Consumer Name & Address

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Veteran: Yes ☐ or No ☐

Check ☒ all that apply: ☐ Disability (specific) \_\_\_\_\_ ☐ Senior

How many people live in this home? \_\_\_\_ Do you own your property? Yes ☐ or No ☐

Amount of monthly rent/mortgage \_\_\_\_\_

What item are you requesting? \_\_\_\_\_

Please describe how this item may assist you? \_\_\_\_\_

**\*Air conditioners may only be funded for individuals with chronic heat related health risks.**

Window Unit \_\_\_\_\_ Portable AC Unit \_\_\_\_\_ Dimensions \_\_\_\_\_

#### Race and Ethnicity Data (optional)

Race and ethnicity information provided by the applicant for services from Heightened Independence and Progress (**hip**) is used for reporting purposes only. Providing this information is optional. Our compiling of such data is expected to benefit the delivery of affiliated services. Information provided (or waiving the option to report this information) will have absolutely no influence on your eligibility for services provided by **hip**.

Check all categories that apply.

Latino	White	Asian	Black or African American	Native American or Alaska Native	Native Hawaiian or Other Pacific Island	Other: Please Specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check ☒ off one:

☐ The above information has been freely and accurately reported, to the best of my knowledge.

**OR**

☐ I choose to exercise my option not to report the requested information.

### Financial Information

**hip** uses the following low-income guidelines set by the Department of Human Services:

Your income for 2024 (100%-200% Federal Poverty Level) Single (\$1,133-\$2,265) Married (\$1,526- \$3,052). Above income, may submit a letter with disability-related expenses and hip will take it into consideration for funding assistance.

Please provide the financial information below: Submit proof of income.

Income Sources	Your income (monthly)	Total household income (Annually)
Employment	\$	\$
Social Security	\$	\$
SSI	\$	\$
Pension	\$	\$
Retirement	\$	\$
VA	\$	\$
Rental	\$	\$
<b>Total monthly income:</b>	\$	\$

Please submit a copy of the following document(s) when you return the 3-page application.

Applications submitted without these document(s) will not be considered, as well as incomplete application.

Additional documents needed to be submitted with this application:

- Doctor's letter/prescription stating your disability and the item you need to accommodate your disability.
- Proof of income, copy of identification and insurance.

**Please review and sign before submitting.**

**Mail to: Heightened Independence and Progress (*hipcil*)**

**Attn: SAIL Program**

**131 Main Street, Suite 120**

**Hackensack, NJ 07601**

Centers for Independent Living are required to have all consumers either complete an Independent Living Plan (Section 1) or sign a statement that they prefer to waive that option (Section 2). **hip** will provide all services to consumers regardless of their choice.

Consumer Name: \_\_\_\_\_

Please complete and sign either Section 1 or Section 2—**not both**.

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**INDEPENDENT LIVING PLAN (Section 1)**

Main Goal: \_\_\_\_\_

Projected Date of Completion: \_\_\_\_\_

Activities to Help You Reach This Goal:

1. Activity: \_\_\_\_\_

Projected Date of Completion: \_\_\_\_\_

2. Activity: \_\_\_\_\_

Projected Date of Completion: \_\_\_\_\_

I was responsible for developing my own plan, and I understand that I may change my plan at any time.

Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**INDEPENDENT LIVING PLAN WAIVER (Section 2)**

Please sign below if you have decided not to do a written Independent Living Plan at this time.

In signing this Independent Living Plan Waiver, I have chosen not to establish goals in writing. I have been informed and understand that I will receive all necessary services from **hip** regardless of this decision. I further understand that I have the right, at any time I choose, to develop an Independent Living Plan.

Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If I am dissatisfied with the services provided to me by Heightened Independence and Progress, I can contact the Client Assistance Program (CAP) at 1-800-922-7233 or 609-292-9742 Voice/TDD.**