

Date: _____
 Name: _____
 Address: _____
 City/State/Zip: _____
 Phone Number: _____
 Email Address: _____

- **Applications will be reviewed by RSDSA's Assistance Program committee case by case. The grant is for non-emergency financial expenses only. It is a one-time award. This grant is to offer assistance with accessibility support, assistance programs, medical, and other non emergency assistance to the CRPS community.**

Application must be filled out in its entirety and be legible to be considered. Please allow sufficient time to be processed.

- Do you currently have CRPS/RSD? Yes No – **If you answered yes, please provide medical documentation that you have CRPS (must be within the one year of the date of this application).**
1. Do you currently have a doctor that is treating your CRPS/RSD? Yes No
 2. Are you currently employed? Yes No
 3. Does your employer provide health insurance? Yes No
 4. Are you currently living on your own or with a caregiver? On my own With a caregiver
 5. If you are living with a caregiver are they? Family Member Friend Paid Position
If this is a paid position, who is paying for it? _____
 6. Are you applying for or currently receiving any of the following?

	Applying for	Received	Amount
SSI	<input type="checkbox"/>	<input type="checkbox"/>	
SSDI	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	When
If denied, have you reapplied?	<input type="checkbox"/>	<input type="checkbox"/>	
Please attach a letter from the Social Security Administration stating that you have applied or have been awarded benefits. (a copy is acceptable)			
	Applying for	Received	Amount
SNAP	<input type="checkbox"/>	<input type="checkbox"/>	
Housing Assistance	<input type="checkbox"/>	<input type="checkbox"/>	
Grant for training or college	<input type="checkbox"/>	<input type="checkbox"/>	
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
Workers' Comp	<input type="checkbox"/>	<input type="checkbox"/>	
Other: such as faith community/Service club	<input type="checkbox"/>	<input type="checkbox"/>	

7. What is the total net monthly income for your household? _____
8. What are your total monthly medical expenses? _____
9. Please include your latest IRS 1040 or 1040EZ (first page only)

10. Do you attend support groups and/or educate yourself on your RSD/CRPS? Yes No
If yes, what groups do you attend or visit on-line?

11. How did you find out about the TJ Whalen Assistance Fund?

12. Why do you feel you should receive assistance from the TJ Whalen Assistance Fund?

13. What are you requesting assistance for? Please summarize your request including costs. If you're applying for assistance to pay for accessibility improvements to your home or for other assistance please provide quotes or other relative information for the amount you are requesting. Previous expenses will not be considered.

REQUEST FOR ASSISTANCE APPLICATION

Please list additional circumstances that you would like us to consider in determining your eligibility. Please attach a typed statement if more space is needed to answer any of the questions. Please send completed application to: slkweiner@rsds.org or mail to RSDSA 99 Cherry Street Milford, CT 06460