Covid19 Community Response Program

FOOD GIFT CARD APPLICATION

Heightened Independence and Progress (***hip***) is providing assistance to individuals with disabilities and their families who have been affected by the COVID-19 pandemic.

As part of our efforts, we will be distributing grocery store gift cards to approved individuals and/or families. Approved recipients/households will receive a Shoprite gift card to assist with grocery purchases.

To be considered for the gift cards, please complete the 2 page application. Incomplete applications will be delayed. One gift card per household per month.

Applications can be emailed to mvalentin@hipcil.org , faxed (201) 996-9424 or mailed to:

Hip
131 Main St. Suite 120 Hackensack, NJ 07601
Attn: Covid19 Community Emergency Response Program

If you are a new applicant to hip, please include, one copy of proof of Bergen County residency:

****PSE&G Bill, Phone bill, Bank Statement, Social Security Award Letter***
(stating name and address of applicant)
****Copy of Proof of income, such as Social Security Award letter, Unemployment or Paystub***

If you have any questions or need assistance with the completion of the application, please contact our office at 201- 996-9100 X18.

Your application can be completed over the phone if you are currently a *hip* consumer.

CONTACT INFO

Full Name

____
____

Address____
_

City____ **State** ____________________**Zip**________________

Phone (Home)_________________________________ **Phone (Cell)**_____________________________

I have a disability or I have a family member with a disability.

- ☐ Yes List disability:____
- ☐ No

Total number of household members under age 18: ____________ **over age 18:** _____________

Monthly Income $_____________________ **Food Stamps $**_________________________

Please let us know how Covid19 has affected your food supply and describe your need____
____
____
____
____
____

The undersigned certifies that the information/answers provided are complete and true. You further agree to the following:

- **I/my family needs financial assistance to purchase food due to Covid19.**
- **I/we understand this gift card is to be used for food/emergency items.**
- **I/we relinquish Heightened Independence and Progress *(hip)* of all liability**

Applicant Signature: __________________________________ **Date:** ___________

Approved by: ____________________________________

Covid19 Community Response Program

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: ____

Name of Parent/Guardian: ______________________________________

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

INDEPENDENT LIVING PLAN (Section 1)

Main Goal: To obtain Covid19 Community Response Program funding to enhance/retain community independence.

Projected Date of Completion: ______________________________________

Activities to Help You Reach This Goal:

1. Activity: To work with the CIL staff to obtain all medical and related documentation, for program eligibility.

Projected Date of Completion: ______________________________________

2. Activity: ____

Projected Date of Completion: ______________________________________

3. 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:** __________

INDEPENDENT LIVING PLAN WAIVER (Section 2)

Please sign below if you have decided NOT to do a written Independent Living Plan at this time. I understand that I will continue to receive IL services and can establish a plan if other services are needed in the future. In signing this Independent Living Plan Waiver, I have chosen not to establish goals in writing. 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.