ARK Advocates
Advocating For & Serving Persons with Disabilities
Request for Financial Assistance

Our mission is to advocate and serve persons with disabilities in choosing where and how they learn, live, work, play, and pray; in partnership with families and the community.

Please complete and return to ARK Advocates, P.O. Box 3024, Dubuque, IA 52004-3024

Name of Person Requesting Financial Assistance _____ Person Receiving Financial Assistance _____

DOB: _____ Age: _____

Address: _____ City, State: _____ Zip Code: _____

E-Mail Contact: _____ Phone: _____

Person lives with ____parents ____mother ____father ____other, please specify _____

Alternate Contact Person, if needed: Name: _____

Adddress: _____ Phone Number: _____

Type of Request: _____Campership: Name of Camp: _____
_____Guardianship/Conservatorship
_____Adaptive Equipment: Describe: _____
(Please attach Therapist/Specialist explanation of and recommendation for the device.)
_____Other; Please Specify: _____

Describe the need and/or circumstances surrounding this request: _____

Are you a current member of ARK Advocates: _____Yes _____No

Family's / Person's Taxable Income
Check the space which indicates your family's **federal net taxable income** for the most recent tax year.

____ 1. $9,999 and under ____ 2. $10,000-19,000 ____ 3. $20,000-39,000 ____ 4. $40,000 and above

Applicant's Disability: Indicate primary and secondary, if applicable: _____

Have you applied for assistance for the above from any other organization? Yes _____No _____

If you answered yes to the above question, explain the organization, date, amount requested, and the results of the request: _____

(See Back Side of Page)

Date Needed By: _____

Total Amount Needed: $_____
Personal Contribution: $_____
ARK Advocates Amount Requested: $_____
Alternative Funding Available: $_____

Please attach any other information you think necessary to evaluate the request.

I understand that the financial assistance monies granted to me by ARK Advocates are to be used solely for the above stated purpose. **Verification of monies spent (receipts, bills paid, etc.) **must be sent** to ARK Advocates no later than 30 days post event, unless previously provided.**

ARK Advocates reserves the right to request information for further verification prior to approval, if necessary.

Signature: _____ Date: _____

*********For Office Use Only*********

Date Received: _____ Date Presented to Committee: _____

Direct Service Committee Decision: _____

_____

_____

_____

Amount Approved: _____ Date Approved by Committee: _____

Method of Payment:
_____ Check to: _____
_____ Gift Card to: _____
_____ ARK Purchase Item from: _____
_____ Other: _____

Committee Member Signature: _____ Date: _____

Date Notified Applicant: _____ Check #: _____