

**BLANCHE ■ ■ ■**  
**FISCHER ■ ■**  
**FOUNDATION ■**

**1509 S.W. SUNSET BLVD., SUITE 1-B**  
**PORTLAND, OR 97239**  
**PHONE: 503.819.8205**  
**E-MAIL: BFF@BFF.ORG ■ WEB: WWW.BFF.ORG**

The Blanche Fischer Foundation is a private, nonprofit charitable institution founded in 1981 for the purpose of assisting persons who have a disability that challenges them physically and who have financial need. There are three criteria for consideration for a grant from the foundation:

1. You must be an Oregon resident;
2. You must have a disability of a physical nature; and
3. You must demonstrate financial need.

Applicants may apply for financial aid for education, special equipment or for such other purposes as the foundation finds appropriate.

**Please Note**

- The application must be filled out completely and signed by the applicant or applicant's legal guardian.
- Medical or other satisfactory verification of disability (letter from physician or other health care professional) is required.
- We do not accept faxed applications. You must MAIL the original, along with documentation, to the foundation. This is necessary for the foundation to comply with state and federal requirements.

**GRANT APPLICATION**

Name of applicant (*person for whom assistance is requested*):

\_\_\_\_\_

Address: \_\_\_\_\_  
Street No. Apt./Unit City ZIP

Telephone/TTY: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

## I. INFORMATION ABOUT YOUR DISABILITY

1. Briefly describe your disability: \_\_\_\_\_  
\_\_\_\_\_
2. How long has this condition existed? \_\_\_\_\_
3. Is your condition permanent?       Yes       No  
If no, expected duration: \_\_\_\_\_
4. How does this affect your daily life and independence? \_\_\_\_\_  
\_\_\_\_\_
5. For what purpose are you requesting funding? \_\_\_\_\_  
\_\_\_\_\_
6. How much does it cost? \$ \_\_\_\_\_
7. How much do you need the Blanche Fischer Foundation to contribute? \$ \_\_\_\_\_
8. How will this grant improve your quality of life? \_\_\_\_\_  
\_\_\_\_\_
9. Name and address of vendor or supplier (*attach copy of price quote or order information*): \_\_\_\_\_  
\_\_\_\_\_  
 **Yes, it's attached!**
10. Have you applied for grants from any other source(s)?       Yes       No  
From whom? \_\_\_\_\_      How much? \$ \_\_\_\_\_
11. Have any been approved?       Yes       No  
By whom? \_\_\_\_\_      In what amount(s)? \$ \_\_\_\_\_
12. Have you ever received vocational training?       Yes       No
13. From whom (state agency, federal, private organization)? \_\_\_\_\_  
When? \_\_\_\_\_  
Did this training result in employment?       Yes       No
14. **Attach a letter or report from your doctor or other licensed health care professional (social worker, case manager, etc.) verifying your disability.**       **Yes, it's attached!**

## II. APPLICATION FOR BENEFIT

*NOTE: ALL household members must be considered in replying to income-related questions.*

### General Information

Applicant's birth date \_\_\_\_\_

If a minor, name of parent(s) or guardian(s): \_\_\_\_\_

Age of each child in household: \_\_\_\_\_

Number and relationship (parent, spouse, caregiver, etc.) of adults in household: \_\_\_\_\_

Number of wage earners in household: \_\_\_\_\_

Occupation(s): \_\_\_\_\_

Employer(s) name(s): \_\_\_\_\_

Work phone (if applicable): ( \_\_\_\_\_ ) \_\_\_\_\_

### Income and Expenses

A. **Monthly INCOME – Salary and Wages:**

1. Primary wage-earner:  
Gross **monthly** salary: \$ \_\_\_\_\_  
**Monthly** take-home pay: \$ \_\_\_\_\_

2. Second wage-earner:  
Gross **monthly** salary: \$ \_\_\_\_\_  
**Monthly** take-home pay: \$ \_\_\_\_\_

B. **Monthly INCOME – Other**

Social Security \$ \_\_\_\_\_  
Child support \$ \_\_\_\_\_  
Food stamps/Oregon Trail \$ \_\_\_\_\_  
Other (describe): \$ \_\_\_\_\_  
\_\_\_\_\_

C. **Monthly EXPENSES**

<b>Category</b>	<b>Monthly Payment</b>	<b>Balance Owed</b>
Food	\$ _____	
Clothing	\$ _____	
Utilities	\$ _____	
Health care (medical, dental, vision, prescriptions, etc.)	\$ _____	\$ _____
Insurance	\$ _____	
Payments (credit cards, car payments, loans, etc.)	\$ _____	\$ _____
Other (describe): _____	\$ _____	\$ _____

D. What kind of **medical insurance**, if any, do you have? Check all applicable responses:

- None
- Private health insurance  Yes  No
- Medicare  Yes  No
- Oregon Health Plan  Yes  No
- Other (describe):  Yes  No  
\_\_\_\_\_

E. **ASSETS**

Do you rent or own your residence?  Rent  Own

What is your monthly payment? \$ \_\_\_\_\_

Do you own any other real property?  Yes  No

If yes, please describe: \_\_\_\_\_

**Automobile(s):**

*Automobile 1*

Make and year: \_\_\_\_\_ Value \$ \_\_\_\_\_

*Automobile 2*

Make and year: \_\_\_\_\_ Value \$ \_\_\_\_\_

**Amount of cash in bank accounts and any stocks, bonds or securities, including retirement plans and living trusts:**

Describe: \_\_\_\_\_

\_\_\_\_\_ Value \$ \_\_\_\_\_

**III. OTHER INFORMATION YOU MAY WISH US TO CONSIDER (attach letter, if desired):**

\_\_\_\_\_  
\_\_\_\_\_

*All grants made assume the accuracy of this application. I understand that if a grant is awarded, payment can be made only to the supplier of goods or services. I further understand that all decisions as to eligibility and grants are made at the sole discretion of the Blanche Fischer Foundation and that its decisions are final.*

*I understand that all grants awarded by the Blanche Fischer Foundation must be reported on the foundation's federal and state tax returns, and as such, grantees' names, addresses and grant amounts are a matter of public record.*

**Signature(s):**

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Parent/Guardian (circle whichever is appropriate)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (circle whichever is appropriate)

**Your response to the following question will not influence in any way the outcome of this grant application:**

Would you like us to send you a Voter Registration Card, along with the names of your state senator, representative and U.S. Congressional representative?  Yes  No

**Before mailing this application . . .**

1.  Are all sections complete?
2.  Have you attached documentation from a medical or other professional verifying disability?
3.  Have you attached a copy of your vendor's price quote?

Mail the completed application and documentation to:

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