

Alaska Mental Health Trust Authority Mini-Grants
Application Instructions
(latest edit – 1.12.2017)

Who Qualifies:

Anyone diagnosed with **Alzheimer’s disease or a related dementia** including Parkinson’s Dementia, Multi-Infarct Dementia (stroke-related), Pick’s Disease, Lewy Body Dementia, Huntington’s Disease or Creutzfeldt-Jakob Disease.

Funding Criteria:

Mini-grants funds may be requested for the following:

- Essential items which will directly improve the individual’s quality of life and increase independent functioning.
- Medical, dental, vision, hearing, supplies, therapeutic devices, adaptive equipment, and accessibility improvements.
- No other funding source is available for the item or service requested. (Other funding includes personal assets, insurance, VA or other grants.) No existing bills.

Review Application Checklist:

1. The beneficiary or the beneficiary’s family member, care coordinator, legal guardian, power of attorney or another person may apply.
2. **If applicable, the signature of legal guardian or power of attorney is needed.**
3. All information on the form must be completed; incomplete applications will be returned.
4. Attach a written estimate from vendor (store, provider or supplier) to be used. If applicable add shipping, handling and/or installation charges. ***Requests to reimburse goods or services that have already been purchased will not be funded.***
5. Verify that person requesting grant has one of the qualified diagnoses listed above. **Please attach verification of ADRD diagnosis to application.** This can be from a physician, physician’s assistant, advanced nurse practitioner or nurse. Please call if you have questions.
6. Verify the physical address of person on application form.
7. Please note the maximum Mini-Grant request is \$2,500; however an applicant may submit more than one application per year, as long as the combined applications do not exceed \$2,500.
8. **Mail or Fax application by 5pm on the 1st Tuesday of each month to:**

Alzheimer’s Resource of Alaska
1750 Abbott Road, Anchorage, AK 99507
Fax (907) 561-3315

How the process works:

Submit a completed mini-grant application with an estimate from the vendor to be used for the item or service requested. Application will not be processed until all information is completed. Completed applications are considered for funding based on level of need and date order. Once a grant is awarded we will notify the applicant and we will send a Purchase Order (PO) directly to the vendor. **Important Note: Do not pay for item or service out of pocket. Payment will be made directly from the Alzheimer’s Resource of Alaska to the vendor for the items or services purchased for the Beneficiary.** A check for payment is sent to vendor after an invoice for completed item or service is received by the Alzheimer’s Resource of Alaska. Grant will not pay for an existing bill. **For additional information visit our website www.AlzAlaska.org or call us at (907) 561-3313.**

These Mini- grants are funded by the Alaska Mental Health Trust Authority and administered by the Alzheimer’s Resource of Alaska.

Alaska Mental Health Trust Authority Mini-Grants Application

Please complete all information. Attach a copy of diagnosis and written estimate for the items or services needed.

Person filling out this application

Name _____
Address _____
City _____ Zip _____
Day Phone _____
Evening Phone _____
E-mail _____
Fax _____
Relationship to Beneficiary _____
How did you hear about us? Alzheimer's Resource of Alaska
 Family/Friend TV/News/Radio
 Professional Newsletter/Website

Physical Address of Person to Receive Grant

(For delivery of items or services)

Address _____
City _____ Zip _____
Name of Facility/ALH if applicable _____

Person who will receive the services or items from this grant

Name _____

Circle Dementia Diagnosis: Alzheimer's Parkinson's
Stroke-related Pick's Disease Lewy Body Huntington's
Creutzfeldt-Jakob Disease

Date of Birth _____ Age _____

Gender (Circle one) Male Female

Ethnic Background (Circle one)

Native Alaskan/Native American Hispanic
Caucasian (Non-Hispanic) Black
Asian/Pacific Islander Other _____

Beneficiary Coverage (Circle yes or no for all options)

Medicaid	Y	N
Medicare	Y	N
Medicaid Waiver	Y	N
VA	Y	N
Personal Assets	Y	N
Other Grants	Y	N
Other Insurance	_____	

Amount of Mini-Grant Request: _____ (Maximum \$2,500)

Specific Item(s) or services to be purchased with this Mini-Grant _____

Explain how this Mini-Grant will allow Beneficiary to receive an essential item, how the item will increase independent functioning, and how it will improve the Beneficiary's quality of life:

Store or supplier (Vendor) from which the item(s) or service(s) will be purchased:

Name of Store or Supplier _____
Address _____ City _____ State _____ Zip _____
Phone _____ Contact Person _____

This Mini-Grant Application must be signed in order to be processed

Please Review Application Checklist on other side

I certify that the information submitted in this form is true and accurate to the best of my knowledge. It is my understanding that the items or services for which I've requested this Mini-Grant are not covered by any other funding source.

Signature of Person filling out application _____ Date _____

Signature of Person to receive grant/legal guardian/Power of Att. _____ Date _____