

Persons in Need (PIN) Application

Kitaro Watanabe Fund Eligibility (Is your child eligible?)

- The PIN Award must directly benefit a child 17 years of age or younger.
- The child must have a serious medical condition, disability or special education need.
- PIN Award preference will be given to families with longstanding residence in Hawaii.
- PIN Award preference will be given to child for whom onetime funding assistance will completely or significantly affect his or her ability to recover from the problem and will facilitate his or her return to productive life.
- PIN Award preference will be given for child in need, including children in poverty and part of a gap group.

Please **PRINT** the entire PIN application and the instructions on how to complete it. The entire application must be completed to be considered for a PIN Award. Please note that although these funds are not a source of emergency funding, every effort will be made to respond in a timely manner. PIN applications may be submitted at any time throughout the year. Applicants should be aware that PIN Awards are made as funding is available.

In Part I and II, please enter all information requested. Please write clearly. Remember to review the eligibility requirements listed above to help you with this application. You must be found eligible to be considered for a PIN Award. Incomplete PIN Applications may not be reviewed.

PART I

Child's Name: _____

Address: _____

City/State _____ Zip: _____

Child's Birth date: _____ Age: ____ Sex: ____ Years of Residence in Hawaii: ____ years

Please check the following:

The child has a serious medical need	(__)	Yes	(__)	No
The child has a disability	(__)	Yes	(__)	No
The child has special education needs	(__)	Yes	(__)	No
The child has an Individualized Education Program (IEP)	(__)	Yes	(__)	No
The child previously received/benefited from a PIN Award	(__)	Yes	(__)	No

PART II

Name of person submitting this application: _____

Address: _____ Relation to child: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email Address: _____

Place of Employment: _____ Occupation: _____

PART III - PURPOSE OF FUNDS

Clearly describe what the PIN Award would be used for. How will it resolve or largely resolve a problem for your child? PIN Awards are paid to a vendor (store, service agency, therapist, etc.), not to you, a family member, or a school, etc. Provide the vendor name, invoice and complete address to which a check can be mailed. A PIN Award should completely or largely resolve the immediate problem your child is experiencing. PIN Awards are not granted for continuous services a child will always need. PIN Awards are not made to cover normal living expenses of any kind unless a one-time PIN Award for such an expense has an immediate positive impact on the problem the child is experiencing. The funding amount requested must be identified exactly and should include all taxes, delivery charges, etc., for the item or service described under Purpose of Funds. Incomplete PIN Applications may not be reviewed.

Purpose of requested funds: _____

Total amount requested: \$ _____ Date funds are needed: _____

To what vendor should the payment be made? Payment WILL NOT be made to the applicant or the child’s school. It must be made to a “vendor.” Be sure to attach the vendor’s invoice.

Name of Vendor: _____

Address: _____

PART IV - SOCIAL SUMMARY

In the Social Summary, the applicant must provide relevant background information, which further explains the child’s problem or need that the PIN Award will resolve. You must identify what alternatives your have already pursued and the outcomes of those efforts. Describe the desired goal for the PIN Award. Be sure to describe any unusual circumstances that will clarify your need for a PIN Award in this section.

Name of Referring Agency: _____

Name of Agency Representative: _____

Relationship to the Child: _____

Agency Address: _____

Please provide a Social Summary which describes the child and relevant background information which further explains the problem or need. State what alternatives have been pursued and the outcomes. Describe the desired goal. Any unusual circumstances should be explained in this section.

NOTE: This section must be completed on a separate sheet of paper by a community professional. For example: medical doctor, social worker, counselor, highly qualified teacher, psychologist, therapist, etc. Clergy or other professionals may complete this section if they are qualified to speak to the needs of the child to be addressed with a PIN Award.

PART V - FINANCIAL STATEMENT

Fill in completely by listing all income and expenses of the household in which the child lives.

Complete this section by listing all of the income and expenses of the household in which the child lives. This section must be filled out accurately, honestly and in complete detail in order to determine financial eligibility for a PIN Award. All PIN Application information is kept confidential.

How many people are supported by this income? _____

<u>MONTHLY Income</u>	<u>Amount</u>	<u>MONTHLY Expenses</u>	<u>Amount</u>
Salary (Net)	_____	Rent/Mortgage	_____
Welfare	_____	Utilities	_____
Food stamps	_____	Water	_____
AFDC	_____	Electricity	_____
DHS General Assistance	_____	Gas	_____
Housing Allowance	_____	Telephone	_____
Social Security	_____	Cable TV	_____
Unemployment compensation	_____	Food (include food stamps)	_____
Workman's compensation	_____	Clothing	_____
Pension or Retirement	_____	Insurance	_____
Supplemental Security Ins. (SSI)	_____	Car (monthly)	_____
Veterans' Benefits	_____	Life (monthly)	_____
Alimony/Child Support	_____	Medical (monthly)	_____
Other Sources (please identify)	_____	Transportation	_____
_____	_____	Gasoline	_____
_____	_____	Bus pass	_____
_____	_____	Personal/Household	_____
_____	_____	Child Care	_____
		Credit Cards	_____
		Loan Payments	_____
		Medical expenses (monthly)	_____
		Medication	_____
		Physician	_____
		Hospital	_____
Total MONTHLY Income	_____	Total MONTHLY Expenses	_____
Total MONTHLY Expenses	_____		
MONTHLY BALANCE	_____	(Subtract expenses from income to get balance)	

ASSETS (Total value of property or assets owned)

Cash	_____
Savings	_____
Real Estate (Home/Land)	_____
Car	_____
Stocks	_____
Bonds	_____
Investments	_____

TOTAL ASSETS _____

DEBTS (Total amount that you owe)

Mortgage	_____
Auto Loan	_____
Family Medical Bills	_____
Family Dental Bills	_____
Educational Loans	_____
Other: _____	_____

TOTAL DEBTS _____

The information provided in this application is complete, true and correct to the best of my knowledge.

Signature of Parent or Guardian

Date

Signature of Referring Agency

Date

Please return application and attachments to:

Learning Disabilities Association of Hawaii
245 N. Kukui Street, Suite 205
Honolulu, Hawaii 96817