
# APPLICATION FOR INDIVIDUAL NEEDS FUNDS

Name of Individual: _____

Address: _____

Primary Diagnosis: _____

Have you checked with your County of Financial Responsibility for funding?
Yes_____ No_____

Initial Amount Requested: _____ 25% Co pay (your payment): _____
Actual Request (ADD's payment): _____

Date funds are needed:_____
Check Payable to:_____
Address:_____

Describe how funds will be used: _____

**Please include copy of receipt, brochure, etc.**

By signing below, I agree that I have read the criteria for Advocates for Developmental Disabilities Individual Needs Fund and that the disability defined above is true and I (we) cannot financially afford the above listed request.

_____

Parent/Guardian/Caregiver/Individual (please circle correct designation)

Date_____ Telephone_____

**Return Application to:**
**Laurie Running, Director**
**1225 Lincoln Ave. So.**
**Owatonna, MN 55060**

**1225 Lincoln Ave. S. / Owatonna, MN 55060 / 507-451-9769 / add_steele@hotmail.com**
**www.advocatesfordevelopmentaldisabilities.com / Laurie Running, Director**