



# Governor's Council for People with Disabilities

## INDIVIDUAL CONSUMER INVESTMENT FUND APPLICATION

**Please review the accompanying guidelines prior to completing this form!**

Name of Individual(s): \_\_\_\_\_  
 Title & Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/Zip: \_\_\_\_\_  
 Phone # Day: (    ) \_\_\_\_\_  
 Email: \_\_\_\_\_

I receive (cannot be your child - circle one, if applicable) SSI SSDI TANF NONE

**If receiving SSDI food per diem and mileage will be your match.**

Have you requested funds from another source?    Yes    No  
 If yes give name of organization: \_\_\_\_\_ amount requested \$ \_\_\_\_\_

**CHECK HERE IF ADVANCE FUNDING IS NEEDED** (only for SSI/SSDI or TANF recipients). Please fill out attached CIF ADVANCED FUNDING REQUEST AND INFORMATION FORM. (Advanced funding requests are considered based on state travel rules)

I am (circle one) a person, the family member of a person with: \_\_\_\_\_

Optional - for demographic information only: I am (circle one) African-American, Caucasian, Hispanic/Latino, Asian, Other: \_\_\_\_\_

Title of event/activity: \_\_\_\_\_

Event location City/State: \_\_\_\_\_

Date(s) from \_\_\_\_\_ to \_\_\_\_\_

Does the registration fee cover any meals?    YES    NO    If yes list: \_\_\_\_\_

### Budget Summary:

Total Cost    \$ \_\_\_\_\_  
 Match    \$ \_\_\_\_\_ (50% unless SSI, SSDI, or TANF)  
 CIF requested    \$ \_\_\_\_\_ (Maximum \$1,000)

### Instructions:

 Please enclose the following information

- A. **Conference Information** - a registration form, agenda and description of activities; which shows prices, etc.
- B. **Approximate Itemized Budget** - including match plus amount of request;
- C. **CIF Purpose Statement and Agreement Form** - To be approved for funds, you must sign an agreement to share the information with others, and to participate in community activities. An outcome form will be required after the conference detailing your plans to fulfill the agreement.
- D. **Application and A-C items:** All information must be received in COUNCIL office by a minimum of 3-weeks before in-state and 5-weeks before out-of-state conferences/events. NO EXCEPTIONS.
- E. If applicable: **CIF Advance Funding Request & Information Form**

For questions, call (317) 233-4551, or [bwade@gpcpd.org](mailto:bwade@gpcpd.org) , fax 317-233-3712  
 Mail to: GCD / CIF- ATTN: Brenda Wade 150 W Market, Ste 628; Indianapolis, IN 46204-2821



## Individual CIF Purpose Statement and Agreement Form

The Council's Consumer Investment Fund (CIF) provides funds to consumers with the purpose of making a long-term investment in the future direction of Indiana. It is anticipated that your participation in this partnership with the Council will further the Council's mission of "Community Inclusion". The Council as an investor expects a return on its investment. Information on the results of the CIF investment is used to determine whether the Council should continue to commit resources to the Consumer Investment Fund and the future direction of CIF.

**Purpose Statement:** (Please write a brief statement that tells how you will use the information in your community or how you or your family will benefit from attending this event.) **Use back page if additional space is needed.**

**Agreement: The Governor's Council for People with Disabilities is pleased to consider providing you with financial assistance to attend an event. In exchange for the financial assistance, the Council requires you to complete the agreement below and return it with your application:**

In return for financial assistance in attending this event I, \_\_\_\_\_ agree to the required activities including completing and submitting an initial outcome form with the claim voucher and receipts within 30 days. I have selected the following two outcome activities:

- See page 5 of the guidelines for a more detailed description of the six activities from which you are to select two including what is involved in each activity and if needed, where to get additional information.

**Please check the two outcome activities you agree to complete:** (See descriptions on page 6 and 7)

- Conduct a disability awareness activity
- Become an active participant in a local policymaking or advisory body
- Perform a media watch, by responding to news coverage about disability issues
- Express your opinion to your state or local legislators related to disability issues
- Express your opinion about state or local policy changes
- Sign up for the Council's Fifth Freedom network to respond disability related concerns

\_\_\_\_\_  
Signature(s)

\_\_\_\_\_  
Date

**TO BE COMPLETED ONLY IF REQUESTING ADVANCED FUNDING**

**CIF ADVANCED FUNDING REQUEST**

**Available only to individuals receiving SSI – SSDI- TANF**

Requests must be confirmed ten days in advance of the date the check or APPROVED advanced payment is needed. Arrange/confirm requests with the Mental Health America of Indiana staff by calling, Kathi DiChiappari at 317-638-3501 ext. 225 or 800-555-6424 as soon as you receive your approval letter

Please check each item for which you are requesting advanced funding (advance funding will not be considered if appropriate box is not checked). The actual amount and items that will be approved for advanced funding may differ from your request (**all expenses can not be paid in advance**).

- Hotel:** Name of hotel: \_\_\_\_\_ Phone # \_\_\_\_\_  
Dates of stay: \_\_\_\_\_ Confirmation # \_\_\_\_\_

\*Hotel conference rate (include rate & tax): \_\_\_\_\_

\*Needed so room rates plus tax can be verified and a check can be issued. Remember to take a credit card or extra cash for a deposit (receipt must be submitted to MHAI once you return).

- Registration** - Enclose a copy of the filled out registration form with the CIF application.  
Send check to: \_\_\_\_\_ Conference sponsor

- Airfare** - When your application is approved, call Mental Health America of Indiana to get authorization to call a specific travel agent with whom they have an account. (receipt must be submitted once you return).

- Car rental** - (not available if you have airfare) Submit invoice or other document from company that shows the fee (receipt must be submitted to MHAI once you return)

Name of company providing travel: \_\_\_\_\_

Telephone number/contact name: \_\_\_\_\_

Travel dates and location: \_\_\_\_\_

Fee: \_\_\_\_\_

**Food allowance - ONLY individuals on SSI and TANF (SSDI match funds)**

- Per diem food allowance** - will be calculated based on state travel rules minus meals provided by conference sponsors. No receipts are needed

\_\_\_\_\_ # of days Meals provided by the conference (list): \_\_\_\_\_.

## Budget

Name(s): \_\_\_\_\_

Have you requested funds from another source? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes give name of organization: \_\_\_\_\_ and amount requested \$ \_\_\_\_\_

**must be deducted from total budget - see below**

* Description	Total	Match (50%)	CIF
<b><u>Conference Registration</u></b>	\$	\$	\$
<b><u>Lodging</u></b>  rate \$ _____ x _____ % tax = \$ _____  x # of days _____ = \$ _____	\$	\$	\$
<b><u>Food Per Diem (match if receiving SSDI)</u></b>  Rate \$ _____ x # of days _____ = \$ _____ x # people _____ = \$ _____ Minus meals provided: _____  Total Deducted \$ _____ Total allowance \$ _____	\$	\$	\$
<b><u>Airline</u></b> Depart from what city: _____	\$	\$	\$
<b><u>Child Care / PCA</u></b>  \$ _____ per day x # of days _____ = \$ _____	\$	\$	\$
<b><u>Parking/Taxi/Shuttle</u></b> (Describe)	\$	\$	\$
<b><u>Mileage (match if receiving SSDI)</u></b> RT mileage _____ X \$.40 = \$ _____	\$	\$	\$
<b><u>Misc. (lost wages MATCH only)</u></b>	\$	\$	\$
<b><u>Sub Total</u></b>	\$	---	---
<b>Subtract amount of funds obtained from other source</b>	\$	---	---
<b>TOTALS</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

## **OVERVIEW OF BUDGET RULES, STATE TRAVEL GUIDELINES, AND OTHER INFO**

Use the following guidelines in preparing your budget. See the sample budget for additional information.

**Mileage is calculated at a flat mileage rate:** Mileage \$.40 per mile (max 2,000 miles). **In all cases, state mileage charts determine vehicle mileage.**

**IF receiving SSDI - mileage and food per diem is used as your match and can not be paid with CIF monies.**

**No receipts are required for meals:**

Meals are \$26 per day for in-state travel (lunch and breakfast \$6.50 each; dinner \$13)

Meals are \$32 per day for out-of-state travel (lunch and breakfast \$8 ea; dinner \$16).

**Deductions are made for any meal provided by the conference.**

Original receipts or invoices must be provided for hotel, airfare (boarding pass), parking, taxi, child/attendant care and ALL OTHER EXPENSES. NO RECEIPTS are needed for food per diem and/or mileage (fixed rates).

**Reimbursement will not be made for more per line item than originally approved.**

Monies received from other sources (ie. Family Involvement Fund etc.) must be recorded on the budget page.

Lost wages can not be reimbursed but will **ONLY** be counted as MATCH.

Only one out-of-state conference **PER FAMILY** every other year will be approved.

Once the Council office approves a request it is sent to the Mental Health America of Indiana who has a contract with the Council. They will mail you information on the submission of receipts, Outcome Reports and vouchers for reimbursement.

Mail/fax applications to:

**GCPD/CIF**

**ATTN: Brenda Wade**

**150 W Market St, Ste 628**

**Indianapolis, IN 46204-2821**

**(317) 233-3712 (fax)**

**bwade@gcpd.org**