



## ALASKA

### Home Modification & Accessibility Grant Program (for Mental Health Trust Beneficiaries and/or individuals with special needs)

#### Applicant Information

(Please print a response to every question)

Name of grant recipient \_\_\_\_\_

Name of person completing the application \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Address or Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Are you the Owner of Record for your home?  Yes  No If No, provide the information below.

Owner's Name \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### Household Information

List all household members, including Head of Household. Attach another page, if needed.

Name	Male	Female	Female Head of Household	Disabled	Age	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	Asian	Black or African American	White	Hispanic or Latino	Not Hispanic



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*Note: Ethnicity information is for government monitoring purposes only.*

Education:  Below High School  High School Diploma or Equivalent  Two-Year College  
 Bachelors Degree  Masters Degree  Above Masters Degree

Are you a Veteran? Applicant:  Yes  No Co-Applicant:  Yes  No

Are you foreign born?  Yes  No What is your primary language? \_\_\_\_\_

If any household members are living in the home on a temporary basis, please explain:

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Read "How do I Know if Someone is a Beneficiary of the Trust" on Page 5, and write the total number of household members who have disabilities that fall within each category:

- 1) \_\_\_\_\_ Mentally Ill
- 2) \_\_\_\_\_ Developmentally Disabled
- 3) \_\_\_\_\_ Chronic Alcoholic with Psychoses
- 4) \_\_\_\_\_ Alzheimer's Disease or Related Disorders
- 5) \_\_\_\_\_ Disabled or Special Needs

Provide a letter from a medical or rehabilitation professional stating that the proposed home improvements are necessary to improve accessibility for the disabled person living in the household or to mitigate the persons functional limitations that result from their condition. This letter may not be written by a household member.

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**Project Information**  
***Properties Must Be Located Within the Municipality of Anchorage***

**Available Improvements**--Housing Modification Grants may be used to improve accessibility or to mitigate the persons' functional limitations that result from their condition in existing permanent or rental housing through facility modifications and improvements, including:

- Stairway modification or ramp installation or modification
- Widening of doors and/or hallways



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- Adjustments to the levels of countertops and other usable surfaces;
- Installation of appropriate bathroom fixtures
- Adjustments and adaptations to improve mobility within the interior living space
- Adaptations to mitigate any functional losses due to traumatic head injuries
- Adaptations to manage behavioral issues associated with Alzheimer’s disease and related disorders
- Installation of permanent technological features designed to improve accessibility and independent living
- Amplification, visual devices, and/or signaling devices to assist hearing and/or visually impaired individuals
- Other housing modifications specifically approved by the Department of Health & Social Services.

Please explain what available improvement can meet your household’s accessibility needs. Be as specific as possible and attach another page if necessary. Submit pictures of the area(s) to be improved so we can understand your needs.

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Have you obtained any bids for the work identified above? If so, please provide copies.

Is there an emergency circumstance that threatens the ability of a household member to remain in the home? If so, please describe. Attach another page if necessary.

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**\*\*\*PLEASE NOTE WE CANNOT REIMBURSE FOR ITEMS ALREADY PURCHASED\*\*\***

Have you applied to any other agency for assistance in meeting these needs? If so, please provide the following contact information. Attach another page if necessary.

Agency Name	Contact Person	Phone



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**Referred by (please check all that apply):**

- Print Advertisement    Bus Advertisement    Bank    Government    TV    Realtor  
 Staff/Board member    Walk-In    Friend    Radio    Newspaper Article
- 

**Walk Away Policy:** The program administrator may exercise discretion, up to and including walking away from the project, in servicing clients when the scope of work exceeds the limitations set for this program or when other detrimental circumstances are associated with the project, location, or applicant. These circumstances may include, but are not limited to, the following.

- A. The program administrator may implement corrective actions including walking away when circumstances endanger workers or contractors.
- B. Remedial actions including walk-away may be engaged when encountering a hostile homeowner.
- C. Finally, measures may be taken, up to and including walking away, when criminal activities are encountered at or associated with the property, the applicant, or the applicant's household.

**Applicant Certification**

I certify that the above information is true and correct to the best of my knowledge and that all adult household members have completed the Authorization for Release of Information on Page 6.

**Penalty for False or Fraudulent Statements: USC Title 18, Section 1001 provides that:**

**(a)** Except as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully—

**(1)** falsifies, conceals, or covers up by any trick, scheme, or device a material fact;

**(2)** makes any materially false, fictitious, or fraudulent statement or representation; or

**(3)** makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry;

shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both. If the matter relates to an offense under chapter 109A, 109B, 110, or 117, or section 1591, then the term of imprisonment imposed under this section shall be not more than 8 years.



**Reasonable Accommodation:** If you or any person in your household needs additional accommodation because of a disability, please explain the accommodation needed on the “Reasonable Accommodation Request Form” provided by the sponsoring organization.

\_\_\_\_\_  
Signature of Head of Household

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-Applicant

\_\_\_\_\_  
Date

**\*\*\*PLEASE NOTE WE CANNOT REIMBURSE FOR ITEMS ALREADY PURCHASED\*\*\***



**How do I know if someone is a beneficiary of the Trust?** Beneficiaries of The Trust include the following broad groups of individuals:

People with mental illness - *Statutory definition [AS 47.30.056(d)]*: Persons with the following mental disorders:

- Schizophrenia;
- Delusional (paranoid) disorder;
- Mood disorders; Anxiety disorders;
- Somatoform disorders;
- Organic mental disorders; Personality disorders; Dissociative disorders;
- Other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and
- Persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection.

People with developmental disabilities - *Statutory definition [AS 47.30.056(e)]*: People with the following neurological or mental disorders:

- Cerebral palsy; Epilepsy; Mental retardation; Autistic disorder;
- Severe organic brain impairment;
- Significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection;
- Other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.
- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and



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- Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

People with chronic alcoholism - *Statutory definition [AS 47.30.056(f)]*: People with the following disorders:

- Alcohol withdrawal delirium (delirium tremens);
- Alcohol hallucinosis; Alcohol amnesiac disorder;
- Dementia associated with alcoholism;
- Alcohol-induced organic mental disorder; Alcoholic depressive disorder;
- Other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

People with Alzheimer’s disease and related dementia - *Statutory definition [AS 47.30.056(f)]*: People, who as a result of their senility, exhibit one or more of the following mental disorders:

- Primary degenerative dementia of the Alzheimer type;
- Multi-infarct dementia; Senile dementia; Pre-senile dementia;
- Other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

For more information please see the following link: <http://www.mhtrust.org/index.cfm>

## NeighborWorks® Alaska

2515 A Street  
Anchorage, AK 99503  
(907) 677-8490 Phone      (907) 677-8450 Fax

### Home Modification & Accessibility Grant Program (for Mental Health Trust Beneficiaries and/or individuals with special needs)

#### Authorization for Release of Information

##### Consent

I authorize and direct any Federal, State, or local agency, organization, business, or individual to release to Anchorage Neighborhood Housing Services Inc. (ANHS) dba NeighborWorks Anchorage to complete and verify my application for assistance under the Home Modification Grant Program.

I understand and agree that this authorization or the information obtained with its use may be given to and used by ANHS dba NeighborWorks Anchorage, State of Alaska Department of Health and Social Services, Alaska Housing Finance Corporation, and the Alaska Mental Health Trust in administering and enforcing program rules and policies.

I understand that I will be required to sign a Promissory Note for a period of three years as a security agreement. Within the three year period, if the property is no longer occupied by a person with special needs relevant to the improvements made, all grant funds must be repaid to the State of Alaska, unless otherwise agreed to by both parties.



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**Information Covered**

I understand that previous and current information regarding my household and me may be needed as it relates to this program. Groups of individuals that may be asked to release this type of information include but are not limited to:

Banks and other Financial Institutions	Medical and Psychiatric Personnel
Child Care Providers	Public Assistance Agencies
Child Support and Alimony Providers	Recording offices
Drug and Alcohol Treatment Personnel	Social Security Administration
Family and/or State-Appointed Guardians	Title Companies

**Conditions**

I agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file at ANHS dba NeighborWorks Anchorage. I understand I have a right to review my file and correct any information that is incorrect. If the modification can be made to help a minor child living in the parent or guardian’s home, the parent or guardian would sign below.

**Signatures Required**

\_\_\_\_\_  
Applicant’s Signature                      Printed Name of Applicant                      Social Security Number                      Date

\_\_\_\_\_  
Adult Member’s Signature                      Printed Name of Adult Member                      Social Security Number                      Date

\_\_\_\_\_  
Adult Member’s Signature                      Printed Name of Adult Member                      Social Security Number                      Date

