

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services  
**Alaska Mental Health Trust Authority Mini-grants for Beneficiaries with Disabilities**

**Application**

Applicant:		Date of Birth:
Address:		
City:	State:	Zip code:
Telephone:	Email address:	
Eligibility: <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Early intervention/Infant Learning Program		
Current funding sources for services:		
<input type="checkbox"/> Community Development Disabilities Grants <input type="checkbox"/> Core Services <input type="checkbox"/> Early Intervention/Infant Learning Program <input type="checkbox"/> Home and Community Based Waiver Services <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Medicaid <input type="checkbox"/> Medical insurance <input type="checkbox"/> Other (Please specify): _____		
Amount requested (Maximum \$2,500): \$ _____ for equipment and/or services to meet the following needs: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Physical/occupational/speech therapy <input type="checkbox"/> Home improvements		
Describe equipment/services requested. <i>Attach supporting documentation, e.g., estimate from a vendor, catalog page/order, or prescription from a licensed health care professional.</i>		
Describe the need which the equipment/services will address.		
Describe how the equipment/services will improve quality of life and increase independent functioning.		
Person completing form:		Telephone:
Relationship to applicant:		
Referring provider agency:		
Agency contact:		Telephone: