ACI CARES ACT ASSISTANCE PROGRAM APPLICATION

Please read the information in our CARES Act Assistance brochure first before completing this application. For more information, contact ACI by email (adacil@adacil.org), phone (732-738-4388), or Video Relay Service (732-709-1023).

In order to be eligible for this program, you must be a person with a disability living in Middlesex, Somerset, or Union counties.

Date *

Name of consumer requesting relief *

Name of person (if different from consumer)

Relationship (if different from consumer)

How did you hear about this program?

Are you a hotline caller? *

- Yes
- No

Do you have a disability? *

- Yes
- No

Are you a family member of a person with a disability living with you? *

- Yes
- No

Are you a resident of Middlesex, Somerset, or Union Counties? *

- Yes
- No

Address *

City

County

State

Zip

Phone (Home) *

Phone (Cell)

Email *

- Sign up for ACI newsletter

What is your disability? *

Date of birth *

Do you identify as... *

- Male
- Female
- Other
- Choose not to respond

What is your nationality? *

- White
- Hispanic
- African American
- Asian
- Other
- Choose not to respond

Service/Assistance requested *

(Check all that apply)

- Housing
- Transportation
- Technology
- Food insecurity
- Basic needs
- PPE
- Other

Please describe your request for assistance, including costs. *

Explain in detail how this request is related to the COVID-19 pandemic. *

(Example: I am having a hard time affording my rent since I lost my job in April 2020. I got laid off due to the pandemic and slow down of the economy.)

Is this a necessity? *

- Yes
- No

Is it COVID-19 related? *

- Yes
- No

Did you already purchase the item? *

(If so, this disqualifies you from the program)

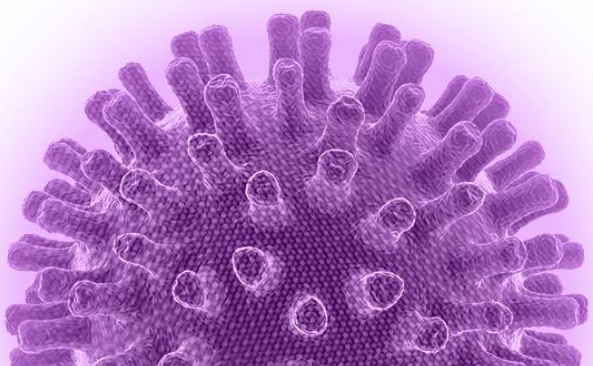
- Yes
- No

Include any information regarding other financial assistance you may have received to assist you. *

(Example: I was receiving unemployment, but that ran out.)

Describe your desired goal or outcome from the request. *

***** = required***



I, _____ agree that the information provided in this application is true and accurate. I agree this request is for myself/ my home, that it is a reasonable necessity as a result of the COVID-19 pandemic.

REMEMBER: DUE TO LIMITED FUNDS, ACI CAN NOT PROVIDE ASSISTANCE TO THE SAME PERSON OR HOUSEHOLD MORE THAN ONCE. ASSISTANCE IS APPROVED AT THE DISCRETION OF ACI CARES ACT ASSISTANCE COMMITTEE. ALL APPLICATIONS WILL BE APPROVED ON CASES BY CASE BASIS.

ACI RESERVES THE RIGHT TO OBTAIN FURTHER INFORMATION REGARDING YOUR APPLICATION.

Please submit or return this completed application to:
Alliance Center for Independence
Attn: CARES ACT
629 Amboy Avenue, Suite 104
Edison, NJ 08837

FOR ACI OFFICE ONLY

- Approved
- Denied

Reason for Denial

Denied Recommendations

Reviewer

Date

Reviewer

Date

Reviewer

Date

Consumer was notified of decision on

By staff

Notes