



Dear Applicant:

CareerSource Broward has received funding from the Department of Economic Opportunity to help **certain** people with disabilities replace or repair medical equipment or assistive devices that were destroyed, lost or damaged due to hurricanes Irma and Maria. **In order to promptly fulfill your request, please follow these steps:**

Step 1: The Self-Attestation Eligibility Application

- Carefully review and complete the enclosed application (through question 6)
- Sign and date the application

Step 2: Record of Disability

- Provide a **record of your disability** by a licensed medical professional or governmental agency

Step 3: Statement of how assistance supports employment

- Provide a statement that explains how the equipment/device helps you, a family or household member with employment or the pursuit of employment (includes job-related training/education)

Step 4: Documentation of costs

- Provide **2 estimates** for repairs or replacement of each item listed under question 5 and/or
- Provide copies of **detailed receipts** for each item/service already paid for

Step 5: Documentation of your residence & right to work

- Attach proof of your address **at the time** of the disaster (see question 4)
- Provide a copy of your SS Card or SSA statement
- If interested in employment services, also provide a copy of one proof of identity document (refer to List A or B documents on the attached page of the Form I-9)

Step 6: Submit your **completed application documents** the following ways:

Mail: Disability Disaster Grant Program Coordinator
 CareerSource Broward 2890 W. Cypress Creek Road Ft. Lauderdale, FL 33309
Fax: 954-337-0999 (ATTN: Disability Disaster Grant Program Coordinator)
E-mail: disabilitydisasterhelp@careersourcebroward.com

If you have any questions or concerns, please feel free to contact me at **954-202-3830 ext. 3120** or at **disabilitydisasterhelp@careersourcebroward.com** for an immediate response.

Sincerely,

Alpha A. Balde
 Disability Disaster Grant Program Coordinator

CareerSource Broward
 Administrative Office
 2610 West Oakland Park Boulevard
 Oakland Park, FL 33311
 P: 954.202.3830 | F: 954.497.1588

Disability Disaster Grant (DDG) Self-Attestation Eligibility Application

Name:		Social Security Number:	
Address:			Apt or Unit:
City:	County:		State:
Telephone #: () - 	Alternative #: () - 		
Email Address:			
Eligibility Information			
1. Do you consider yourself to have a disability? Yes <input type="checkbox"/> No <input type="checkbox"/>		2. Florida has a system to provide help for job seekers through a statewide network of CareerSource centers. Are you interested in receiving information about services provided through the CareerSource network? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Do you need to replace or repair medical or assistive devices because they were lost or destroyed due to Hurricane Irma or Maria? Yes <input type="checkbox"/> No <input type="checkbox"/>			
4. What was your address at the time of either Hurricane Irma or Maria? Please provide documentation (e.g., State Issued ID, utility bill, mail, etc.). _____			
5. Which type of service do you need? Check all that apply.			
• Equipment/supplies <input type="checkbox"/> What type? _____			
• Physical construction for accessibility <input type="checkbox"/> What type? _____			
• Device <input type="checkbox"/> What type? _____			
6. Has the equipment/supplies or physical construction for accessibility or devices been totally or partially paid for or reimbursed by another agency or insurance company? If so, please list the agency/insurance company: _____ Yes <input type="checkbox"/> No <input type="checkbox"/> If partial payment, indicate amount paid: \$ _____			

Please provide two written estimates for repair/replacement of a device or, if already purchased, provide a detailed receipt.

Attestation Statement: All of the above information is true and correct to the best of my knowledge. I understand that I will have to pay back CareerSource Broward and I may be subject to civil and criminal penalties should a monitoring or audit of this application prove any of the information provided to be false.

_____ _____
Customer Signature Date

For Staff Use Only:

Region #	Date of Request:
Is the expense being reimbursed to the customer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, do you have a paid receipt? Yes <input type="checkbox"/> No <input type="checkbox"/> What is the cost to be reimbursed \$ _____	
Is the expense being paid to a vendor(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the vendor(s) on the State Contract List? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If "No," do you have the necessary written quotes to pay the vendor(s)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
What is the name(s) of the vendor(s) to be paid? _____	
What is the cost to be paid to the vendor(s)? \$ _____	
I provided information to this client regarding services available through the CareerSource Network and a referral to LWDB _____.	

_____ _____
Staff Name (Printed) Staff Signature

_____ _____ _____
Staff Phone Number Email Date

An equal opportunity employer/program. Auxiliary aids and services are available upon request to individual with disabilities. All voice telephone numbers on this document may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711.