South Carolina Assistive Technology Loan Application

General Approval Guidelines

Basic Eligibility:

1) Applicants and Co-Applicants must be current residents of South Carolina.
2) Assistive Technology (AT) Loans- Items/products purchased must be DIRECTLY related to the type of disability of the AT end user.
3) AT applications must provide certified medical letter (doctor's note, counselor, therapist, etc.) dated within the last 60 days indicating the type of disability.

Credit:

1) The applicant must be able to repay the amount of the monthly payments for the full term of the amount financed.
2) Approval is based on debt to income ratios along with willingness to repay.
3) The applicant cannot be in Chapter 13 Bankruptcy.
4) The applicant may not have repossession within the last 24 months.
5) Medical Collections are not taken into consideration for qualifying applicants.

Loan Limits

1) Maximum loan amount is $30,000.00 for SECURED LOANS.
2) Maximum loan amount is $10,000.00 for UNSECURED LOANS.
3) Minimum loan amount is $1,000.00 for both types of loans.

Vehicle Purchases

1) Vehicles cannot be over 10 years old from the current year.
2) Used vehicles cannot have a mileage reflecting more than an average of 20,000 miles per year.
3) GAP insurance is required on any vehicle approved for the loan programs.
4) Applicant must provide a Certified Inspection Report and Vehicle History Report on vehicles that are not purchased new.
5) Applicant must agree to the Hold Harmless Clause.

****BEFORE YOU SEND IN YOUR APPLICATION****

(Use this checklist to make sure the application is completed correctly)

Application Checklist

- ☐ All information is filled in, including "N/A" or "NONE" for items that do not pertain to you
- ☐ All Signatures and Dates completed with current date
- ☐ Authentic Quote or Estimate for All items or services included in the purchase request
- ☐ Quotes or Estimates match the amount requested in application
- ☐ Certified Medical Document stating the type of disability that the applicant, co-applicant or AT user currently has
- ☐ Certified Medical Document must be dated within the last 30 days
- ☐ Copy of South Carolina ID or Driver's License and Social Security Card for all person's on application
- ☐ Proof of Income documents provided within the last most recent two months
- ☐ Also include other income such as Investments, Retirement, Pension, 401K, Trust, etc..
- ☐ Self-Employed: provide last two year's copies of IRS transcripts from tax returns

***Purchasing a Vehicle?

- ☐ Copy of Auto Insurance Quote for the specific vehicle to be purchased
- ☐ Copy of Certified Vehicle Inspection report/ Carfax

SOUTH CAROLINA ASSISTIVE TECHNOLOGY LOAN PROGRAM

LOAN APPLICATION INSTRUCTIONS

1. **Please review the guidelines before completing your application.**
2. **If you have a co-applicant or guarantor, both you and the co-applicant must complete the appropriate sections.**
3. **Please make sure that your application is filled out completely, signed and dated.**
   Application will expire 30 days after the date listed on the application by applicant
4. **Please include the requested documents with your completed application:**
   a. **An invoice, bid, official estimate, or other information showing cost of item with description of the equipment and/or services to be provided (if vehicle, must include estimate for full coverage insurance).**
   b. **Documentation of Disability – Must be dated within the last 30 days (i.e., letter from physician, letter from Social Worker or VR Counselor, Evaluation Report, etc.) **Must be from a qualified/certified professional****
   c. **Photocopy of a current state issued ID for each applicant, co-applicant, and AT User**
   d. **Verification of Income. Examples are as follows:**
      - **Copy of the letter from SSI, SSDI, VA**
      - **Pension Income**
      - **401K Income**
      - **Investments, Trusts, or other income sources**
      - **If currently employed – Most recent 2 months paystubs**
      - **If currently self-employed – Most recent 2 years tax returns**

The South Carolina State Credit Union will conduct a credit check on each individual who completes a financial information form.

RETURN COMPLETED APPLICATION AND ALL SUPPORTING DOCUMENTS TO:

P.O. Box 3197
West Columbia, SC 29171

Email: info@scatloans.org
Fax: (803) 822 – 8948

The South Carolina Assistive Technology Loan Program is a federally-funded project of the National Institute for Disability and Rehabilitation Research (NIDRR), US Department of Education, under PL105-394, the Assistive Technology Act of 1998, and Grant No. H224C030024. The South Carolina Assistive Technology Loan Program is provided as part of a cooperative partnership with South Carolina State Credit Union.

South Carolina Assistive Technology Loan Program
Privacy Policy & Disclosure

The Gramm-Leach-Bliley Act requires us to tell you what steps we take to safeguard the privacy of the financial information you provide to us. Here is a summary of our privacy and disclosure policies.

Our Privacy Policy

We may collect non-public personal information about you from the following sources:

- Information we receive from you on your loan application
- People and organizations identified on your loan application
- Information about your transactions with us, our affiliates or others
- Information we receive from a consumer credit reporting agency

What We Disclose

We do not disclose any non-public personal information about our customers or former customers to anyone except as permitted by law.

Telling Your Story

We may use "your story" (for example, why you needed a loan, what equipment or technology you purchased and how it impacted your life) to explain and market our program to other borrowers and contributors. However, we will not identify you by name unless you give us permission to do so. If you do not wish to have your story told, please let us know at the time of your application. It will not affect loan eligibility.

Confidentiality & Security

The South Carolina Assistive Technology Loan Program takes every precaution to ensure that your personal information remains private. Accordingly, we restrict access to non-public personal information about you to employees and agents of the South Carolina Assistive Technology Loan Program, members of our Loan Review Committee and Board on a need-to-know basis and guarantors, co-signors, vendors and providers who need to know that information to provide products or services requested by you. We maintain physical, electronic and procedural safeguards to comply with federal regulations to guard your non-public personal information.

Question

If you have any questions or concerns about our privacy and disclosure policies, or to receive a list of general guidelines regarding the S.C. Assistive Technology Loan Program, please contact the South Carolina Assistive Technology Loan Program.

SC Assistive Technology Loan Program
P.O. Box 3197
West Columbia, SC 29171

Phone: (803) 726-7143
Email: info@scatloans.org
Fax: (803) 822-8948

Part I

South Carolina Assistive Technology Loan Application

Name of Applicant:______________________________ Date: ______________

Mailing Address:____

City:__________________ State: _____ Zip: ________ County:__________

Length of Time at this Address? ______Years _____ Months

Phone:________________ Cell:______________ Work:______________

Email:____

Birthdate:________________ Social Security Number:________________

Assistive Technology (AT) User's Type of Disability: (check all that apply)

_____ Vision
_____ Hearing
_____ Speech Communication
_____ Mobility, seating and positioning
_____ Daily Living, handling objects, reaching
_____ Learning new information
_____ Remembering
_____ Social/Interacting with others

List & describe equipment and services you want to purchase.

*****MUST attach an invoice, bill of sale or bid from the vendor showing total cost of loan amount*****

Equipment or Service	Cost	Estimated Life of Device
______________________	$ ______________	______________
______________________	$ ______________	______________

Please describe, in your own words, how this technology will be used and how it will benefit you or the AT User.

____
____
____

Amount of Loan requested: $________________

*****MUST MATCH ESTIMATE TOTALS PROVIDED*****

If you receive the AT loan, would you have insurance to cover loss or damage to equipment?

Yes_____ No______

Are you a client of South Carolina Vocational Rehabilitation Department?

Yes______ No______

Is the applicant the person with the disability?

Yes______ No______

If "No", please explain the relationship to the person with the disability and list their full name

Relationship: ______________________ Full Name: ______________________

PART II

DEMOGRAPHIC INFORMATION FOR USER OF ASSISTIVE TECHNOLOGY (AT)

This background information helps us to determine who we are serving. We are requesting this information in accordance with the Equal Credit Opportunity Act and the requirements of the regulatory agencies. Providing the information is voluntary and it will not in any way be a factor in the application approval process.

Name (if different from applicant): ____________________

Gender: ___ Male ___ Female Age: ________

Ethnic/Racial Background:
___ Caucasian ___ Hispanic ___ Asian/Pacific Islander
___ African American ___ Native American ___ Other:

Language Spoken At Home:
___ English ___ Spanish ___ Chinese ___ Korean ___ Vietnamese ___ French ___ Other:

Marital Status:
___ Single with no dependent children
___ Married or Domestic Partnership
___ Widowed
___ Single with dependent children
___ Divorced
___ Other (please describe)________

Employment Status:
___ Employed Fulltime ___ Employed Part-time ___ Self-employed Fulltime
___ Self-employed Part-time ___ Unemployed ___ Retired on disability
___ Retired ___ Student (Level completed :______________)
___ Homemaker ___ Other (Please describe)

Are you actively seeking work?
___ No ___ Yes – Fulltime ___ Yes - Part-time

Housing Status:
___ Subsidized Rental Unit ___ Rent ___ Own Home or Condo ___ Other (Please describe):

Veteran Status
___ None/Not Applicable ___ Veteran

How did you hear about AT's low interest loans? (check all that apply)
___ Advertising (e.g., ___TV,___ radio,___ newspaper)
___ Information from the Internet
___ Professional (e.g., OT, PT, doctor, case manager)
___ Bank, credit union or lending institution
___ Other:______________________________
___ Don't know
___ Information received in the mail
___ Friend
___ Disability-related agency:
___ Equipment vendor, supplier or dealer

I currently am covered by the following public/private programs.
___ Medicaid
___ Private Health Insurance
___ Division of Developmental Disabilities
___ Food Stamps
___ Vocational Rehabilitation
___ Medicare
___ Disability Insurance
___ Special Education or 504 Plan
___ Workers Compensation
___ Other

PART III
MONTHLY BUDGET WORKSHEET - APPLICANT

Applicant Section *Please Complete All Lines That Apply*		For Internal Office Use Only
MONTHLY ASSETS/DEBT/EXPENSES ITEMIZED	PER MONTH	**NET MONTHLY INCOME $**
Checking Account Balance	$	
Savings Account Balance	$	Total Assets
Stocks & Bonds	$	
Real Estate Owned (free and clear)	$	
Retirement Fund Balance	$	
Net Worth of a Business Owned (free and clear)	$	
Vehicles Owned (free and clear)	$	
Other Assets	$	
Rent or Mortgage	$	Total Debt
Homeowners Association Dues	$	
Property Taxes	$	
House/Renters Insurance	$	
Electric	$	
Gas	$	
Heating Fuel	$	
Water	$	
Security System	$	
Garbage Removal	$	
Health Insurance Premiums	$	
Other Insurance	$	Total Expenses
Monthly Credit Cards & Other Debt	$	
Retirement Plan	$	
Child Care or Child Support	$	
Internet Connection	$	
Cable TV	$	
Telephone	$	
Cell Phone	$	
Food & Household Items per month	$	
Furniture Accounts	$	
Club Memberships/Dues	$	
Vehicle Payment	$	
Vehicle-Maintenance & Repairs	$	
Vehicle-Insurance (including new insurance)	$	
Vehicle-Gas (Current and/or Projected)	$	
Other Transportation (mass transit, cabs, etc)	$	**EXPENSES + DEBT**
Savings	$	
Charitable Contributions, Tithes, memberships	$	**EXCESS INCOME**
Cigarettes & Alcohol	$	
Entertainment (video rentals, movies, eating out)	$	**DEBT TO INCOME RATIO**
Vacations	$	
Other: (laundry, clothing, haircuts, makeup, birthday)	$	
Taxes: For Self Employed Only	$	
Medical Care (co-pays, glasses, medications, supplies)	$	TOTAL RATIO
Other:	$	
Other:	$	
Other:	$	

PART III
MONTHLY BUDGET WORKSHEET – CO-APPLICANT

Co-Applicant Section *Please Complete All Lines That Apply*		For Internal Office Use Only
MONTHLY ASSETS/DEBT/EXPENSES ITEMIZED	PER MONTH	NET MONTHLY INCOME $
Checking Account Balance	$	
Savings Account Balance	$	Total Assets:
Stocks & Bonds	$	
Real Estate Owned (free and clear)	$	
Retirement Fund Balance	$	
Net Worth of a Business Owned (free and clear)	$	
Vehicles Owned (free and clear)	$	
Other Assets	$	
Rent or Mortgage	$	Total Debt
Homeowners Association Dues	$	
Property Taxes	$	
House/Renters Insurance	$	
Electric	$	
Gas	$	
Heating Fuel	$	
Water	$	
Security System	$	
Garbage Removal	$	
Health Insurance Premiums	$	
Other Insurance	$	Total Expenses:
Monthly Credit Cards & Other Debt	$	
Retirement Plan	$	
Child Care or Child Support	$	
Internet Connection	$	
Cable TV	$	
Telephone	$	
Cell Phone	$	
Food & Household Items per month	$	
Furniture Accounts	$	
Club Memberships/Dues	$	
Vehicle Payment	$	
Vehicle-Maintenance & Repairs	$	
Vehicle-Insurance (including new insurance)	$	
Vehicle-Gas (Current and/or Projected)	$	
Other Transportation (mass transit, cabs, etc)	$	EXPENSES + DEBT
Savings	$	
Charitable Contributions, Tithes, memberships	$	EXCESS INCOME
Cigarettes & Alcohol	$	
Entertainment (video rentals, movies, eating out)	$	DEBT TO INCOME RATIO
Vacations	$	
Other: (laundry, clothing, haircuts, makeup, birthday)	$	
Taxes: For Self Employed Only	$	
Medical Care (co-pays, glasses, medications, supplies)	$	TOTAL RATIO
Other:	$	
Other:	$	
Other:	$	

PART IV
FINANCIAL INFORMATION FORM

	Applicant	Co-Applicant
Gross Monthly Household Income	$________	$________
Net Monthly Household Income**	$________	$________

Sources of Income (At least one type below **MUST** be selected)

	Applicant	Co-Applicant
• Employment:	$________	$________
• SSI:	$________	$________
• SSDI:	$________	$________
• Social Security:	$________	$________
• Savings/Investments:	$________	$________
• Pension/401K:	$________	$________
• Other Disability Income:	$________	$________
• Trust:	$________	$________
• Other (Describe):	$________	$________

Applicant Employment:

Company Name:________

Company Address:________

____

Position:________

Supervisor's Name:________

Company Phone #:________

Length of Employment for above?________

Co-Applicant Employment:

Company Name:________

Company Address:________

____

Position:________

Supervisor's Name:________

Company Phone #:________

Length of Employment for above? ________

***Alimony, child support or separate maintenance income need not be listed unless you want it to be considered in granting credit.*

AUTHORIZATION/CERTIFICATION

I certify that the information provided in this application is true and correct to the best of my knowledge. Authorization is hereby given for the release of any and all information concerning bank accounts, employment, and credit or mortgage verification as requested by South Carolina Assistive Technology Loan Program. I understand that South Carolina Assistive Technology may need to contact other agencies and individuals to determine my eligibility and to verify my need for the support for which I am applying. I authorize the release of such confidential information.

____

Signature of Applicant **Date**

____

Signature of Co-Applicant **Date**

____

Name & contact information of person who assisted with application (if any):

Loan Application

Please Sign and Date the Application in the spaces provided at the bottom of the form.

Primary Applicant Information

Account Number (if current member, otherwise leave blank) ______________________

Social Security Number ______________________

Name ______________________

Address ______________________

City ______________________

State ______________________

Zip ______________________

Email ______________________

Are you a U.S. citizen or a permanent resident alien? ☐ Yes ☐ No

Mailing Address

Mailing Address ______________________

City ______________________

State ______________________

Zip ______________________

Home Telephone ______________________

Work Telephone ______________________

Work Extension ______________________

Employment Information

Employer ______________________

Date Employed ______________________

Employer Address ______________________

City ______________________

State ______________________

Zip ______________________

References

Number of Dependents ______________________

Next of Kin ______________________

Relationship ______________________

Relationship phone ______________________

Income and Housing Costs

Gross Monthly Income ______________________

Notice: Alimony, child support or separate maintenance income need not be revealed if you do not choose to have it considered.

Income Source ______________________ example: employment

Other Income ______________________

Other Income Source ______________________ example: investments, rental property

Residential Status ______________________ Own, Rent, Other

Rent or Mortgage Payment ______________________

Loan Request

Purpose of Loan ____

Amount Requested ______________________

Collateral ____

Repayment Method ☐ Cash Payroll Deduction Other ________________

Co-applicant Information (Optional)

Co-applicant Name ____

Co-applicant SSN ______________________

Co-applicant Employer ____

Co-applicant Address ____

City ____

State ______________________

Zip ______________________

Co-applicant Gross Income ______________________

Notice: Alimony, child support or separate maintenance income need not be revealed if you do not choose to have it considered.

Is co-applicant a U.S. citizen or permanent resident alien? Yes No

Upon completion of this application – I[We] authorize you to obtain information, including a consumer credit report, to check my credit or other banking records.

______________________________ ______________________

Applicant Date

______________________________ ______________________

Co-applicant Date

STATE CREDIT UNION*

ACCOUNT CARD/APPLICATION FOR MEMBERSHIP & SERVICES

NEW MEMBER EXISTING MEMBER MEMBER # DATE

STEP 1: TELL US ABOUT YOURSELF PLEASE PRINT ALL INFORMATION

Full Name | SSN or TIN | Date of Birth

E-mail | Mother's Maiden Name | Name of Employer

Gov't Issued ID # | Issuer | Issue Date | Expiration | If different Mailing Address

Street Zip Address | City | State

Home Phone ( ) | Work Phone ( ) | Cell Phone ( )

STEP 2: ESTABLISH YOUR MEMBERSHIP

☐ **MEMBERSHIP SAVINGS ACCOUNT** (Holds your required $5 ownership share in SCU) or ☐ **MINOR SAVINGS ACCOUNT** (Coindexter Club , Ages 12 and under)

MEMBERSHIP ELIGIBILITY: (Live or work in community, family, employment, other)

____

STEP 3: SERVICES REQUESTED

☐ **CHECKING ACCOUNT** (Also, Visa Check Card & overdraft line of credit) **Account Type:** ☐ **First** ☐ **Relationship** ☐ **Loyalty** ☐ **Value** ☐ **Club**

1) Give my Visa Check Card ATM access to ___ checking ___ savings **2)** ☐ Provide Visa Check Card to joint owner with ATM access to ___ checking ___savings

☐ **OVERDRAFT INSTRUCTIONS** *Overdraft transfer priority*; please number 1, 2, 3 . Overdraft Line Of Credit* ___ Membership Savings ___

☐ Do not transfer from any account ☐ I/ we opt-out of standard overdraft privileges

*A separate application may be required for this service. No protection from a loan account is provided unless approved for an overdraft loan account.

☐ I/ we **opt-in for one-time ATM and debit card purchase transactions** (Review "Information on Overdrafts and Overdraft Fees" disclosure)

IMPORTANT: TRANSFERS FROM SAVINGS ARE LIMITED TO SIX (6) PER MONTH. AFTER SIX TRANSFERS FROM SAVINGS IN ONE MONTH, ADDITIONAL ITEMS PRESENTED FOR PAYMENT AGAINST INSUFFICIENT FUNDS MAY BE RETURNED AND MAY RESULT IN FEES TO YOUR ACCOUNT. _______ *Please initial*

☐ **OTHER ACCOUNTS:** ☐ **Holiday Club** ☐ **Minor's Account** ☐ **POD Account** ☐ **Secondary Savings Account** ☐ **Money Market Account**

☐ **TERM SHARE CERTIFICATE** ☐ **IRA CERTIFICATE** ☐ **IRA SAVINGS ACCOUNT** (IRA accounts may not be jointly held, and a separate application is required.)

☐ **UGMA/UTMA ACCOUNT** **Successor Custodian/Trustee:** ______________________________

☐ **SELF SERVICE CONVENIENCE** (Choose any or all of these free services to make accessing your accounts easier)

☐ Direct deposit ☐ Payroll deduction/draft ☐ ATM card (access to ____ savings ___ checking)

STEP 4: DESIGNATE THE OWNERSHIP FOR YOUR ACCOUNTS AND COMPLETE THE INFORMATION BELOW FOR THE ADDITIONAL ACCOUNTHOLDER.

JOINT (**ALL** accounts selected will be jointly owned if this card lists any "joint owner(s), with exception of IRA accounts.)

TRUSTEE -- TITLE OF ACCOUNT (if different from member's name above)

____

CUSTODIAN -- TITLE OF ACCOUNT (If different from member's name above)

____

1) Full Name | SSN or TIN | Date of Birth

E-mail | Mother's Maiden Name | Name of Employer

Gov't Issued ID # | Issuer | Issue Date | Expiration | Street Address

Home | Work | Cell | If different