

Grant Procedures for Individuals

What We Fund

It is our intent that the organization provide financial assistance aimed at improving the lives of families or individuals affected by Friedreichs Ataxia.

Criteria

Funding will be evaluated based on the following criteria:

1. Does the project to be funded fall in line with organization's vision and mission?
2. Does the project enhance the organization objectives?
3. Does the project to be funded fall in line with the organization's program priorities?

Deadline

The Foundation for a Miracle reviews grant applications as submitted. Applicants will be notified whether grant requests are awarded within six weeks of the date submitted.

Grant Amounts

Awards will be determined based upon the amount of funds available, as determined by the Board of Directors.

Grant Approval

All grant money awarded will be based on:

1. The program budget and priorities established by the Board of Directors
2. Advisement by the organization's Board of Directors after consultation with any advisors they deem appropriate

Guidelines

1. Families or individuals to receive grants must be affected by Friedreichs Ataxia.
2. Applicant must provide independent verification that project will improve the situation.

Reporting Requirements

Requirements as noted in the Grant Agreement, which will be signed upon acceptance of terms of funding, include:

Three month reporting requirements include:

1. Current work product (pictures, emails/testimonials/memos and other concrete examples of project achievements).

Annual reporting requirements include:

1. 1-2 page narrative of project progress since grant awarded; narrative should include opportunities and challenges that lie ahead.
2. Current work product (pictures, emails/testimonials/memos and other concrete examples of project achievements).
3. Financial report which includes dollars spent on particular items and receipts where appropriate.



61 Evandale Road
Rochester, NY 14618
info@foundationforamiracle.org

Title: _____	Grant Number: _____
	Application Date: _____
	Approval Date: _____
Office Use Only	

Grant Application for Individuals

1. PERSONAL DATA: (please print)

Applicant Name & Relationship to Person with Disability: _____

Name of Person with Disability: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell number: _____

Person's Date of Birth: _____ Male or Female: _____

2. CHECK IF YOU RECEIVE ANY OF THE FOLLOWING:

- Medicare Medicaid SSI (Supplemental Security Income)
- WIC (Women/Infant/Child) State Aid SSD (Social Security Disability)
- PHCP (Physical Handicapped Children's Program)
- Private Health Insurance (List name of carrier) _____

3. RESOURCES ATTEMPTED FOR FUNDING OF THIS PARTICULAR ITEM OR SERVICE:

Have you tried for funding from Primary Medical Insurance, including flexible spending accounts?

Yes No

If No please explain: _____

If Yes Result: _____ List any Charities contacted: _____

Have you tried for funding from Medicaid? Yes No Result: _____

List other reimbursement agencies applied to for this particular request:

Agency: _____ Date: _____ Result: _____

Agency: _____ Date: _____ Result: _____

Agency: _____ Date: _____ Result: _____

4. WHAT IS THE ITEM(S) OR SERVICE REQUESTED FOR REIMBURSEMENT?

Total Amount Requested: \$ _____ Period of time requesting for: _____
Cost of item(s): \$ _____ If Service, how much cost per hour session: \$ _____
Amount requesting for Service: \$ _____

5. HOW DOES THIS REQUEST DIRECTLY INHANCE THE FUNCTIONALITY OF THE CONSUMER'S DISABILITY? (add a page if necessary) _____

6. SERVICE COORDINATOR OR SOCIAL WORKER:

Name Agency Phone # Fax #

7. CHECKLIST OF REQUIRED DOCUMENTS: (please attach to application)

- ORIGINAL QUOTATIONS OR ESTIMATES. (list which agency has original if copies are mailed)
- LETTER FROM PHYSICIAN OR PROFESSIONAL TO SUPPORT REIMBURSEMENT REQUEST (if applicable)

I understand that for the purpose of reimbursement services, information may be shared with and received from other agencies. I understand all information contained submitted on this document to be accurate and truthful. I also understand that any fraudulent statements made with the intent to defraud the Foundation to Seek a Miracle Committee will disqualify me from the review process and or result in my paying back any monies given to me by the foundation.

Requester Signature Date

Final determination of eligibility for Reimbursement Services will be determined by the The Foundation For A Miracle Board.

Return completed form to:

**Foundation For A Miracle
61 Evandale Road
Rochester, NY 14618**

<input type="checkbox"/> Acceptance	<input type="checkbox"/> Denial	<input type="checkbox"/> Letter Sent	Office Use Only
Date Paid: _____			
Invoice: _____		Vendor: _____	
Check #: _____		Amount: \$ _____	