WARRIOR FAMILIES BEATING SPINA BIFIDA FOUNDATION

Checklist and Grant Application

In addition to the Grant Application, the following documents must also be submitted. An application will not be considered complete unless WFBSB Foundation has received all applicable items on this checklist. **Funding not awarded for needs that have already been paid for.**

- ❑ Completed Foundation Grant Application form. **
- ❑ Letters (on official letterhead) from the doctor and/or medical specialist giving the recommendation for the treatment/apparatus that is being requested. **
- ❑ Evidence of the family's financial situation. Provide a document, written and signed by you, stating your lack of ability to pay and why. Include most recent Federal Income Tax return, copies of past 4 check stubs, etc.
- ❑ Letter (on official letterhead) of denial from insurance/Medicaid *when applicable.*
- ❑ Letter from doctor or hospital confirming inability to pay *when applicable.*
- ❑ Children's Hospital Release Form *when applicable.*
- ❑ Information on the procedure/apparatus/ need requested. This should include: the cost; if it will be discounted; the name, address and phone number of the company and provider who will receive payment; and how the requested procedure/apparatus will improve the child's quality of life.
- ❑ A photo of the child
- ❑ Consent/refusal to allow your child's picture, story, and/or name on the WFBSB Foundation website, in our newsletter, or in the media. **

I hereby certify that all above information submitted and the statements I have made are true, and agree that any false information, misrepresentation, or omission of facts may result in cancellation or immediate dismissal of my application and possible prosecution.

Signature:_____

Date: _____

**** No exceptions**

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Consent Form

We occasionally like to show our supporters the pictures and stories of children they have helped. If you don't want your child's picture used outside of the application process within the Foundation, please let us know below. ***Your child's last name will NEVER be used in any external media or print materials.***

- ☐ You MAY use my child's picture/first name/story on the website, in the media, across social media platforms, in the Help-A-Child Program, and/or in a Foundation newsletter.
- ☐ You may use my child's picture and story but please change his/her first name.
- ☐ You may use my child's name and story but please do not use his/her picture.
- ☐ I do NOT want my child's picture/name/story used on the website, in the media, across social media platforms, in the Help-A-Child Program, and/or in a Foundation newsletter.

I understand that:

☐ *There are no guarantees that my child' request will be funded through this program.*

☐ *Participation in the Help-a-Child program is not required in order to be eligible for a grant from WFBSB Foundation.*

☐ *By checking one of the first 3 options and signing below, my child' picture and/or story can be used throughout any social media outlet including, but not limited to, Facebook, Twitter, YouTube, Pinterest, and the WFBSB Foundation Website.*

Signature:

Date:

Information about the Help-A-Child Program

Because of the great demand from families like yours, WFBSB Foundation has formed a program called Help-A-Child through which a business, family, church, etc. can choose to fulfill some or all of the need for a specific child that has been *approved pending funds*. This personal donation page will go to businesses and groups who have expressed an interest in directly making an impact for a particular child. It will also be available on the website. Once the Grant Committee has approved your application, they decide, based on the request and the funds available, whether to place the request in the Help-A-Child program. If funds become available before your child's request is fulfilled , WFBSB will complete the request. It is *anticipated* that most requests will be filled within 6 months.

We do ask, should your request be fulfilled through the Help -A-Child program, that you would write a thank you note from you and your child (with a picture if possible) to the group who adopted your need and send it to the WFBSB Foundation office for us to deliver to your donor(s).

The candidate's parent or guardian must complete this application in full before the board will

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review the case. Please be sure to include all additional documents listed on the Grant Application Submittal Checklist. All information submitted is confidential.

Questions? Please contact:
Jessica McCulloch - Ohio
740-661-5024Phone
740-661-5024 Fax - please inform me before faxing
www.warriorfamiliesbeatingspinabifida.org

Application Date: _____

Candidate Information

Name _____ **Age** _____ **D.O.B.** _____ **Gender** _____

Family Information

Mother's Name _____ Telephone Number _____

Address _____ Cell Phone Number _____

City _____ County _____ State _____ Zip _____

Place of Employment _____ Occupation _____

Email address _____

Father's Name _____ Telephone Number _____

Address _____ Cell Phone Number _____

City _____ County _____ State _____ Zip _____

Place of Employment _____ Occupation _____

Email Address _____

Siblings - first name(s) and age(s): _____

Primary caretaker of the candidate: _____

Annual household income $ _____

Type of health insurance coverage _____

Out-of-pocket medical expenses in the last year for candidate $ _____

Do you currently receive funds/assistance from any of the following? (please circle all that apply):

BCMH Social Security MR/DD

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Clinical Information

Name/address/phone number of physician(s) associated with current care

Clinical diagnosis:

Candidate age at onset of illness:

Description/history of child's illness or health condition:

Fun Information

Please tell us some fun things about your child (likes, accomplishments, etc.) and your family

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Request

Description of request: _____

_____

_____

_____

How will this request improve the child's life? _____

_____

_____

_____

_____

Total amount requested from WFBSB Foundation $ _____

Date funding is needed: Explain _____

_____

_____

If funding been sought from additional sources, please list from whom?

_____

If funding has been received, from whom and in what amount?

_____

Any additional information relevant to the request

_____

How did you hear about WFBSB Foundation?

_____

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Please fill in appropriate information related to your request below. It is only necessary to fill in the relevant categories. WFBSB requires that money be sent directly to the treatment provider, apparatus, company, hospital, etc. and not directly to the recipient family. Please indicate the appropriate third party in each of the relevant categories.

If you are listing needs in more than one program area, please number those needs in order of importance and/or urgency.

❑ **Therapy / Treatment Assistance** ~ Allows for needed therapy.

Type of therapy/treatment _____

Purpose _____

Number of treatments/visits Cost per treatment/visit $ _____

Will doctor/organization participate with WFBSB Foundation through a discount? _____

If grant is awarded, who will receive payment? Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

❑ **Building On** ~ Modifications to a child's home environment.

****Please include any contractor quotes you have gotten as well as copies of drawings, if applicable.**

Description of Need: _____

Purpose: _____

Cost $ _____

Will contractor participate with WFBSB Foundation through a discount? _____

If grant is awarded, who will receive payment? Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

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❑ **Travel Assistance** ~ Miscellaneous needs that improve the quality of life for children with special needs. This includes displacement costs should a child need to travel outside their resident area for treatment/surgery, as well as respite care, adaptive strollers, etc.

Description of Need:

Purpose: Cost $

Will a doctor/organization/business participate with WFBSB through a discount?

If grant is awarded, who will receive payment? Name

Address City State Zip

Phone

Type of adaptive equipment:

Estimated life of equipment? Is used equipment an option?

Displacement Request

If displacement funding is provided, the receipts must be provided to WFBSB verifying how the funding has been utilized. The funding will be paid directly to a third party whenever possible. Please note that funding will only be granted to the candidate and one parent/guardian. In addition, a letter will be required from the doctor or medical specialist recommending the treatment be handled outside of the child's city of residence.

Transportation

Purpose of travel:

Travel between which cities:

Method of transportation (please fill in the appropriate information):

☐ Car

Number of round trips Estimated round trip mileage

☐ Plane

Number of individuals Number of round trips Cost/adult $ Cost/child $

☐ Train

Number of individuals Number of round trips Cost/adult $ Cost/child $

☐ Public Transportation

Type of transportation Number of individuals Number of round trips Cost/trip $

If grant is awarded, who will receive payment? Name Address

City State Zip Phone

Lodging

Number of nights: Type of lodging:

Cost per night $ Is charitable housing an option?

If grant is awarded, who will receive payment? Name

Address City

State Zip Phone

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❑ **Mobility Assistance** ~ Transportation assistance required for a child's medical needs to be met. *$7500 max for vehicle and equipment. $5000 max for vehicle only or equipment only*

Equipment (lifts, tie downs, etc)

Description of Need _____

Purpose _____ Cost $ _____

Will provider participate with WFBSB through a discount? _____

Type of equipment _____

Estimated life of equipment? _____ Is used equipment an option? _____

If grant is awarded, who will receive payment? Name _____

Address _____ City _____

State _____ Zip _____ Ph _____

Vehicle

****Please note that grants for vehicles are limited each year. New vehicles are not an option.**

Description of Need: _____

Maximum amount of cash that family can give as a down payment $ _____

Maximum amount family can give for 12 –18 monthly payments $ _____

Description of Need: _____

We would like a vehicle with no more than _____ miles on it _____

Description of Need: _____

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❑ **Medical Equipment for Kids** ~ Equipment/supplies needed to sustain or improve the quality of life for a child.

Equipment Request

Type of equipment: _____ Estimated life of equipment? _____
Cost of equipment $ _____ Is used equipment an option? _____
If grant is awarded, who will receive payment? Name _____
Address _____ City _____
State _____ Zip _____ Phone _____

Supply Request ~ special formula, medication, etc.

Name of formula/medication: _____
Purpose: _____
Size (if applicable): _____ Number of months needed Cost per month $ _____
Will provider participate with WFBSB Foundation through a discount? _____
If grant is awarded, who will receive payment? Name _____
Address _____ City _____
State _____ Zip _____ Phone _____

I hereby release, hold harmless and indemnify the Warrior Families Beating Spina Bifida Foundation, its directors, trustees, officers, employees, volunteers and agents from and against all claims, liabilities, losses, costs, damages or expenses, including reasonable attorney fees and litigation expenses, resulting from or in connection with any treatment, medication, apparatus, transportation, lodging or other benefit that is awarded to me by WFBSB Foundation pursuant to my grant request. In addition, I certify that all of the information that I have submitted and all of the statements that I have made in support of this grant request are true, and I agree that any false information, misrepresentation or omission of facts by me may result in the cancellation or immediate dismissal of my application and that WFBSB reserves the right to take any necessary action to recover any benefits, or the value of any benefits, awarded to me in reliance upon such false information, misrepresentation or omission of facts.

Signature: _____

Date: _____