The Scott Coopersmith Stroke Awareness Foundation

GRANT GUIDELINES & APPLICATION FOR ASSISTANCE

The grant application is for individuals living in Florida with injuries resulting from a stroke. The Foundation's Board of Trustees meets monthly; however, you may submit your application at any time during the year. Applicants will be contacted no later than 30 days after the Board of Trustees' meeting. Grants are awarded based on need and will go into a queue to be paid.

If a family has outstanding treatment-related expenses that insurance will NOT cover, our Foundation can possibly help out a family in need until our annual funds have been exhausted. Once the Foundation determines your eligibility, we will contact you confirming what funds may be provided to which provider(s) on your behalf. If the information in our application is complete and we cannot help you with funds you will be notified. We reserve the right to ask for additional documentation to aid in our grant review process.

The Scott Coopersmith Stroke Awareness Foundation

Today Date:_____*Person completing application: _____

***Relationship to Patient: _____**

***Patient's full name: _____**

***Patient phone number:_____**

***Patient email addresses_____**

***Patient Address: _____**

In the space below, please address each question asked, in detail, specifically and completely. If needed, you may use a separate sheet of paper to

1) **Please tell us in a concise manner about the condition of the patient and prognosis. Include dates, services utilized and/or needed, etc.**

2) **Please tell us about your financial situation. Include information about the financial impact your medical condition has had on you and your family. Include dates, current job status and the impact of the patient's medical condition on employment.**

3) **Provide detailed information about the outstanding/current treatment expenses related to the applicant's condition. This should include the name of the organization (for example, name of physical therapist), description of services provided/to be provided, cost of services, treatment covered by insurance etc.**

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If you are approved for financial assistance from The Scott Coopersmith Stroke Awareness Foundation, by signing this application, you are giving The Scott Coopersmith Stroke Awareness Foundation permission to publish your story, including your name and use your picture if/when needed for Social Media and other purposes related to the foundation.

I,_____give The Scott Coopersmith Stroke Awareness Foundation permission to talk on my behalf regarding patient _____.

Your signature:_____Date:_____

STATE OF_____

COUNTY OF _____

The foregoing instrument was acknowledged before me on_____by _____ who is personally known to me or has produced _____as identification.

_____
Notary Public - State of Florida

_____

(Seal)

Please submit this completed, detailed signed form to: (deanna@strokeawarenessfoundation.org)