



GRANT APPLICATION

**FAMILY MEDICAL ACCESS
FOR
PEDIATRIC SPINE CARE**

Instructions

To apply for medical access funding, please complete the application form, attach any additional required materials and e-mail to the CSF Executive Director: tsthilaire@childrensspinefoundation.org.

General Guidelines

- ❖ Applications for funding need to be related to travel required for pediatric spine care.
 - Funds can support travel for patient and one caregiver.
 - Funds can be used to support car and/or air travel and lodging fees.
 - Funds cannot be used to reimburse the cost of clinical care.
- ❖ Applicants are required to demonstrate financial need. Applicants may be required to provide documentation supporting this need.
- ❖ Applications need to provide evidence that a care pathway has been determined.
- ❖ Funds are for planned medical trips that have been approved by the Evaluation Committee, not for treatment that has already been completed.
- ❖ All correspondence will be sent to the primary applicant. It is the responsibility of the primary applicant to provide all receipts and documentation to the CSF Executive Director.
- ❖ Applicants can request for funding multiple times.

Selection Process

Grant applications are reviewed by the Evaluation Committee of the Children's Spine Foundation. Applications are reviewed on the basis of their financial need and their relation to pediatric spine care.

All persons submitting an application do so with the understanding that they will abide by the conditions, policies, and decisions of the Committee.

Statement of Conditions

It is understood that any funding approved by the Children's Spine Foundation will be made on the following conditions:

- ❖ Applicant will submit estimated expenses, including any electronic estimates, communication with institution regarding lodging fees, and any other support documentation for review with the application.

- ❖ The Foundation will provide the amount approved based on the application. No additional funding will be approved following the completion of the trip.
- ❖ The amount of the award will be expended for the support of the person and purpose described in the application and none of the funds will be diverted to any other expenses. The applicant will immediately notify the Foundation if support for the same person or purpose is received from other sources, in which case, the award will terminate and the balance will be returned to the Foundation.
- ❖ A report detailing expenditures including copies of all receipts will be furnished to the Executive Director within 7 days after completion of the trip. Any unspent funds will be returned to the Foundation.
- ❖ If for any reason the purpose for which funds allocated cannot be completed, a full refund of the grant monies will be made to the Foundation.
- ❖ If for any reason the purpose for which funds were allocated is terminated prematurely, a full accounting of the funds expended to the time of termination will be furnished to the Executive Committee within 7 days of such termination and all unexpended funds returned to the Foundation.
- ❖ The Foundation will not provide funding for "indirect" charges, including but not limited to tips, food, change fees, etc.
- ❖ Should the applicant not provide documentation of expenses within 7 days, 3 attempts will be made by the Foundation to attain this information. Following this, the Foundation will enlist a collection agency to assist in returning all funding to the Foundation.
- ❖ If funding is declined by the Committee, the applicant may apply again if there is a future need.

Publicity

As a recipient of the Medical Family Grant sponsored by the Children's Spine Foundation, you will be asked to sign a publicity release form. You are under no obligation to do so. These pictures will be used to secure additional funding to support other families in need. If you consent, please send pictures of the trip to the CSF Executive Director. These pictures should include candid pictures of your family, radiographs, and any clinical pictures.

Grant Application

Patient Name: _____ (last) _____ (first) DOB: _____ (m / d / yy)

Parent/Legal Guardian Name: _____ (last) _____ (first)

City, State: _____ Telephone: _____

Email: _____

Referral Source

Physician Name : _____

Institution: _____ Telephone: _____

Attach:

Brief medical history including diagnosis, current needs, past treatments, etc.

Copy of most recent full spine xray (AP/lateral)

Copy of supporting medical records

Annual Household Income: \$ _____ /yr Number of People in Household: _____

Statement of Understanding and Authorization

I have read, understood, and agree to abide by the statement of conditions and guidelines provided by the Children's Spine Foundation for the Family Medical Access for Pediatric Spine Care grant application. I certify that all information provided in the grant application is accurate. I authorize the Children's Spine Foundation to discuss and share medical information provided with participating Foundation reviewers and referral source for the purposes of evaluation.

Printed name of Applicant: _____ Signature of Applicant: _____

Date: _____

Promotion Consent

I hereby give my consent to the Children's Spine Foundation (CSF) to use my (child's) name, photograph, story and statements, and medical information, such as diagnosis and treatment, in any promotional materials (printed or electronic). I understand that my (child's) name, photographs and/or video images may be used in a publication, print ad, direct-mail piece, electronic media, or any other form of promotion. I release the CSF, the photographer, their offices, employees, agents, and designees from liability for any violations of any personal or proprietary right I may have in connection with such use.

I have read and understood this consent and release.

Child's Printed Name: _____ Child's Signature (if able): _____

I certify that I am a custodial parent and have the aforementioned rights to assign.

Parent/Guardian Printed Name: _____ Parent/ Guardian Signature: _____

Date: _____