Grant Application

Name: _____ Date: _____

Address: _____ State: _____ Zip: _____

Phone: _____

Individual this request will benefit: _____ Age of Individual: _____

Individual's Diagnosis: _____
**Please attach documentation supplied from the Individual's doctor pertaining to diagnosis.

Item being requested: _____

Have you tried to secure funding through the Individual's insurance company? Yes ☐ No ☐

Is the Individual enrolled in Medicare or Medicaid? Yes ☐ No ☐

Is the Individual enrolled in MHDS? Yes ☐ No ☐

** If yes to any of the above, please attach denial letter to this document.

To what other organizations is the Individual aligned? _____
Have you attempted to get the requested item from any of the organizations listed? Yes ☐ No ☐
** If yes, please provide denial letter.

Does a physician believe this item could help the Individual? Yes ☐ No ☐
** If yes, please provide a note from the physician. If no, please describe on the back of this form why you think this item will help.

The above information is correct to the best of my knowledge. Shall the donation be approved, I will use the donated item for the purpose listed.

_____ _____
Signature Date

OFFICE USE ONLY

Approved ☐ _____ Item Cost: _____
Signature

Denied ☐

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