The Ariane Thomas-Lutchmedial Foundation
For Traumatic Brain Injury

(347) 746 9274
19509 90th Ave
Hollis NY 11423
Email: arianezoe@gmail.com
Website: arianefoundation.org

Grant application form

The Foundation frequently assists families and children with Traumatic Brain Injuries, Cerebral Palsy or similarly related brain disorders. In order to receive an award, you must complete this request form along with a justification and submit to the Board for approval. Members of the board and their immediate families are not eligible for awards to avoid any conflict of interest issues.

Applicants Name ____Date______________

Address____

Telephone (mobile) ________________________________Other____________________________

E-mail address____

Relationship to child____

Child's Information

Child’s Name____ Date of Birth______________

Diagnosis/Disability____

____

____

Justification for award (you may attach documentation)

____

____

____

If parent is not filling out the application:

Guardian’s Name____Phone #:_________________

Address(if different from above)____

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Primary Medical Insurance? ____

Have they been contacted about covering any therapy being requested? If yes, please submit determination letter. If no, why not?

____

Are you receiving any other assistance from other foundation(s) or similar organization(s)?

Yes ______No______

If yes, please list the organization(s) and amount of funding

1. ____Amt. funded________

2. ____ Amt. funded________

3. ____ __________Amt. funded________

Approximate Household Income (check one):

________under $50,000 _______Between $50,000 and $100,000___________Over $100,000

How many family members in household?_______________________________________

Pediatrician or Primary Physician Information

Name ____

Medical Practice Name ____

Address ____

Phone Number__________________________ Fax Number_________________________

E-mail and/or Website Address ____

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Therapy Information (if applicable)

Current level of therapy:

Physical_______ times per week Occupational____ times per week

Speech________ times per week Other Therapy_______________

Type of Therapy, Equipment or Financial Aid Requested

Physical ____ Occupational ________ Equipment______Other: _______

Description of Therapeutic Activities (if applicable)

____

____

Goals that the additional sessions will help my child to achieve (if applicable):

____

____

____

____

My child has engaged in this type of therapy before _____ Yes _____ No

My child is currently or has been a patient of this therapist within the last 12 months

_____ Yes _____No

Cost of each session $ _________________Number of sessions requested _______________

Physical, Speech or Occupational Therapist Information

Name ____

Clinic/Rehab Facility Name____

Address____

Phone Number ___________________________________Fax Number____________________

E-mail/Website Address

____

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Is there any additional information you would like to share to help us make a determination?

____
____
____
____
____
____

If you do not receive assistance this quarterly cycle, would you like your application to be considered during the next cycle? _____ Yes _____ No

Optional (Your response will not affect our decision): if you are the recipient of an award, do you give The Ariane Thomas-Lutchmedial permission to use your child's photo or information in our promotional materials? Yes______No_______

Please send all completed, signed original copies of the application materials to:

The Ariane Thomas Lutchmedial Foundation for Traumatic Brian Injury

19509 90th Ave, Hollis NY 11423 or email to arianezoe@gmail.com

The Foundation may also contact other foundations, therapists or physicians if additional information is required or to verify your information after the application is submitted.

____ Date_________

Signature (Parent of Guardian)

If this is related to a request for an Institutional facility (e.g. Physical Therapy) to provide services, please have an authorized representative complete the following:

____ ______________________

Authorized Facility Representative Printed Name Date

____ ______________________

Authorized Facility Representative Signature Date

The Ariane Thomas-Lutchmedial Foundation does not discriminate on the basis of race/ethnicity, color, national origin, sex, disability, economic status or age with regards to providing funding or purchasing adaptive equipment.