

Paige’s Princess Foundation, Inc.

912 McBurney Drive

Lebanon, OH 45036

2017 Grant Qualification Guidelines

Please read these guidelines carefully and note that we cannot fund previously received goods or services (or any debt reduction) and must have all documentation before funding will be considered. Contact [paigealessandrofund@gmail.com](mailto:paigealessandrofund@gmail.com) with questions or to see how long the wait for funding would be. Applications will be considered until December 1, 2017.

**COMMUNICATION WILL BE VIA EMAIL SO PLEASE PRINT EMAIL ADDRESS CLEARLY.**

Paige’s Princess Foundation is a non-profit organization providing grants to pediatric patients with life-long physical/cognitive/psychological disabilities. Grants will be made to finance adaptive equipment or therapeutic services.

1. Grants will be paid directly to the licensed company, facility, manufacturer, business, service provider or individual that the goods or services are provided by.
2. Paige’s Princess Foundation will not consider requests for debt reduction or reimbursement for previously provided good or services.
3. Applications will be accepted only for children under the age of 21.
4. Applicants must live within 100 miles of the greater Cincinnati area.
5. Applicants must submit medical documentation detailing the lifelong disability, verifying income and referring the requested treatment/equipment from a third party. We cannot consider the application until all documentation is submitted.
6. The maximum grant amount for one year will be $2500. Applicants may only apply once for their most pressing need (applications with multiple needs will be asked the priority) in a calendar year. This would include iPad applications.
7. All funds must begin to be used within 60 days of the grant award. All funds not used within the calendar year 2017 will be forfeited. Recipients must respond via email to accept the grant within 30 days.

A. General Information (Child)

Please Print

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

Gender ❑ Male ❑ Female

How did you hear about Paige’s Princess Foundation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in receiving information/volunteering at Paige’s Princess Run?

\_\_\_\_\_\_YES \_\_\_\_\_NO

Have you received financial assistance from Paige’s Princess Foundation previously?

\_\_\_\_\_\_YES \_\_\_\_\_NO If yes, please list amount and use/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. Medical Information

Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Age of Diagnosis \_\_\_\_\_\_\_\_ Year of Diagnosis \_\_\_\_\_\_\_\_

Please describe your child’s current problems/limitations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Treatment (Please include information about the type of therapy and frequency if applicable)

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Please provide the name/address/phone number of physician(s) and therapist(s) associated with your case.

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C. General Information (Parent/Guardian) Please complete the section for all parents providing financial support or care.

Please Print

Relationship to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print clearly, this is how we will communicate with you)

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Siblings \_\_\_\_\_\_\_\_ Names & Ages of Siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Household Income \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (must provide documentation)

Type of Health Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of out-of-pocket medical expenses in the last year (do NOT include premiums for coverage) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other assistance received (such as social security, BCMH, or MR/DD or other charitable grants)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional parent:

Relationship to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D. Explanation of Use of Grant

❑ Medical Equipment (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Therapeutic Services (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ iPad (child must be at least 4 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide any additional information you feel relevant when considering this grant.

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Estimated Cost $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please include photos, quotes, etc. if applicable.

Will you accept a used item if applicable? ❑ Yes ❑ No

If you are awarded, who will receive payment? (N/A for iPad)

Name of Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time to fill out this application.

We will review it and contact you as soon as a decision has been made.

If we are able to award you the grant, please be advised that we will require a medical release form to be completed for each of the physicians, specialists, therapists, etc. These forms will be sent at a later date.

I hereby release, hold harmless and indemnify Paige’s Princess Foundation, its directors, trustees, officers, 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 Paige’s Princess 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 Paige’s Princess Foundation 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.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE SUBMIT COMPLETED APPLICATION TO:

Heather Alessandro

912 McBurney Drive

Lebanon, OH 45036

Release to use photo on website/Facebook

I hereby authorize Paige’s Princess Foundation to publish the photographs taken of me and/or the undersigned minor children, and our names, for use in the Paige’s Princess Foundation’s printed publications, online media and website.

I release Paige’s Princess Foundation from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize Paige’s Princess Foundation to use their photographs and names.

I acknowledge that since participation in publications and websites produced by Paige’s Princess Foundation is voluntary, neither the minor children nor I will receive financial compensation.

I further agree that participation in any publication and website produced by Paige’s Princess Foundation confers no rights of ownership whatsoever. I release Paige’s Princess Foundation, its officers, trustees, and its employees from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children

We will only use the first name of any recipient.

Paige’s Princess Foundation is dependent on public donations and accountable to our supporters. It is necessary that we promote and demonstrate the ways in which we are able to help our recipients. Your cooperation would be very much appreciated.

Please check one:

\_\_\_\_ I allow use of my child’s photo for Paige’s Princess Foundation.

\_\_\_\_\_ I do NOT allow use of my child’s photo for Paige’s Princess Foundation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Thank you for your application. Our Board will carefully review your application and a decision will be made within 4-6 weeks. We are not able to deliver equipment to private homes at this time.

Supporting Documentation which **must** be included:

\_\_\_\_\_ Therapist or Physician Letter

\_\_\_\_\_ Insurance Denial (if applicable)

\_\_\_\_\_ Proof of Income

\_\_\_\_\_ Photo of Child (to be published only if release is signed). Please include even if we are not to use it as it publicly.

Failure to include all supporting documentation will result in a delay or inability in processing your request. We cannot consider applications which do not meet our documentation requirements.