Michelle M. Adey Memorial Fund, Inc.

Supporting Families. Easing the Journey. Honoring Her Memory.

GRANT APPLICATION

YOUR PRIVACY MATTERS
Information provided will be kept strictly confidential and used only to review your request for assistance.

1 CHILD INFORMATION

Child's name: _____ Date of birth: _____

When diagnosed: _____ Current illness/diagnosis: _____

Is your child covered by health insurance? ☐ Yes ☐ No Insurance company/plan: _____

2 PARENT OR LEGAL GUARDIAN INFORMATION

Mother/guardian name: _____ Phone: _____

Father/guardian name: _____ Phone: _____

Email address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Mother/guardian employer: _____ Position/title: _____

Father/guardian employer: _____ Position/title: _____

3 OTHER CHILDREN OR DEPENDENTS

Are there other children or dependents in your household? ☐ Yes ☐ No

If yes, names and ages: _____

4 DIRECT FINANCIAL NEEDS RELATED TO YOUR CHILD'S ILLNESS

What expenses are related to your child's illness? (Check all that apply.)

- ☐ Travel / gas
- ☐ Lodging / hotel
- ☐ Meals
- ☐ Lost wages from travel or care
- ☐ Child care for other children
- ☐ Home accommodations
- ☐ Special diet / nutrition
- ☐ Medical equipment / supplies
- ☐ Other (specify below)

Details / other expenses: _____

5 HOW DID YOU HEAR ABOUT US?

☐ Hospital/provider ☐ Friend/family ☐ Social media ☐ Other nonprofit

Other / details: _____

6 ADDITIONAL COMMENTS

Please share anything else about your family, needs, or how this assistance will help:

_____

_____

7 REFERENCES (OPTIONAL)

Professional name / role: _____ Phone/email: _____

PLEASE PRINT AND MAIL YOUR COMPLETED APPLICATION TO:

Michelle M. Adey Memorial Fund, Inc.
Attn: Mary Carmel Wolf, Secretary
8572 Teugega Pt. Rd.
Rome, NY 13440