

MICHELLE ADEY MEMORIAL FUND GRANT APPLICATION

Today's Date \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_  
(first) (last)

DATE OF BIRTH \_\_\_\_\_

ILLNESS \_\_\_\_\_

WHEN DIAGNOSED \_\_\_\_\_

PARENTS' NAMES MOM \_\_\_\_\_ Dad \_\_\_\_\_  
(first name/maiden name/last name) (first last)

PARENTS' MAILING ADDRESS \_\_\_\_\_

PARENTS' PLACE OF EMPLOYMENT

MOM: \_\_\_\_\_

DAD: \_\_\_\_\_

ARE THERE OTHER SIBLINGS? / DEPENDENTS? \_\_\_\_\_

CURRENT TREATMENTS/HOSPITALIZATION

WHAT ARE YOUR FINANCIAL NEEDS **DUE TO THIS ILLNESS..... AT THIS TIME?**

ADDITIONAL COMMENTS

REFERENCES? \_\_\_\_\_

**Please Print and Complete**

**Mail to:**

Attn: Mary Carmel Wolf, Secretary  
8572 Teugega Pt. Rd.  
Rome, NY 13440