**Application for an Individual Grant**

**Eligibility**:

Individual grants are awarded to persons living with a spinal cord disability. Friends for Michael Inc. (FFM) is a regional organization that only awards grants to people in the state of Kentucky. Friends for Michael, Inc. does not award cash grants. When an individual grant is awarded, FFM pays the monies directly to the organization or individual providing the product or service that you are requesting. Your application must be accompanied by a written estimate that includes terms of payment, an outline of work/product that will be provided and a projected date of completion/delivery.

**Instructions:**

Print and fill out the application completely. Use additional paper for the essays, then attach them to the application and mail to:

Friends for Michael, Inc.

P. O. Box 212

Campbellsburg, KY 40011

**Privacy:**

Please note that your information will be kept private and not sold or shared with any other organization. You may, from time to time, be contacted by FFM regarding events, volunteer opportunities and other organization activities.

**Questions may be directed to Linda Berry at (502)608-6276; by email to: friendsformichaelinc@gmail.org.**

**Step One**: Submit your application for review.

**Step Two**: We will contact you to set up a personal interview with a designated liaison.

**Step Three**: Our Board of Directors will review your application and the report from our liaison’s personal conversation with you.

**Step Four**: Our Board of Directors will select the recipients. All decisions are final.

**Friends For Michael, Inc.**

**Application for Individual Grant**

**Required Information**:

Name of Injured Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (evening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Caregiver (or person who authorized to speak with us on your behalf)

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

Telephone (day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (evening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are requesting financial assistance from other organizations, please list them:

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

**Amount Requested**: $\_\_\_\_\_\_\_\_\_\_\_\_ (use the estimates to decide on an amount)

**Is this request time-sensitive? (circle one) YES NO**

If so, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Essay Section – Part 1**:

In 300 words or less, please tell us about your situation.

**Essay Section – Part 2**:

In 300 words or less, please tell us how a grant would substantially contribute to your quality of life.

**Financial Section**:

Please attach a written estimate, terms of payment, an outline of work/product that will be provided and a projected date of completion/delivery.

Please include a letter from your doctor or rehab specialist stating the need for the equipment or service.

**Thank you for your interest in receiving a grant from FFM!**

**Signature of person filling out this request**

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

**Date \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_