Jake's Help from Heaven Technology Application

Jake's Help from Heaven, founded in 2011, is a non-profit dedicated to supporting individuals with complex medical needs and disabilities resulting from congenital or childhood-onset diseases. Our primary objective is to improve the livelihoods of these persons as they confront the challenges of managing lifelong, debilitating illness.

Please read the following requirements carefully. Incomplete applications or those submitted in unacceptable formats will not be reviewed.

Grant Eligibility:

- Grants are limited to individuals living within 100 miles of Saratoga Springs, New York.
- Grants are restricted to individuals with complex medical needs and disabilities resulting from congenital or childhood-onset diseases. Applicants of all ages with lifelong, debilitating illnesses are welcome to apply.

Grant Criteria:

- Grants will be awarded for technology devices, such as but not limited to tablet devices and software applications. The Board of Directors will determine the minimum requirements for the technology device being requested.
- Applicants must specify how the technology device will be used for education/communication or quality of life purposes.
- Completion of the following application with the signature of pediatrician/primary care doctor or social worker.
- A doctor's prescription and/or a professional letter of medical necessity by a doctor, therapist, teacher, or care worker. The letters of medical necessity must be signed and dated, preferably on letterhead.
- Proof of payment is required for reimbursement or vendor information for direct purchase. We do not award money for general donations or support.
- Applicants should submit their completed applications with all required documents at one time, and not in separate pieces.
- Electronic applications must be submitted in PDF format. We DO NOT accept jpegs or screenshots.
- There is a $2,500 cap per applicant per calendar year. Applicants may apply multiple times within a calendar year but are only eligible to be awarded a total of $2,500 within that year.
- All iPads include an AppleCare protection plan. It is the applicant's responsibility to contact AppleCare directly in the event of any damage to the product. JHFH will not consider applications requesting a replacement iPad within two years of the original purchase date.
- Grants will be reviewed four times per year at the Board of Directors' quarterly meetings. Approved grants will be awarded approximately 2 weeks after each meeting. Application deadlines and meeting dates can be found on Jakeshelpfromheaven.org.

Section A: Personal Information

Applicant's Name: Age:

Parent/Guardian's Name:

Address:

City: State:

Zip:

Daytime phone #: Evening phone #:

Email address:

Contact information for the individual completing the application (if different from applicant/guardian):

Name: Relationship to Applicant:

Email: Phone number:

Describe your medical condition and the hardships it creates.

Section B: Application Details

Grant amount request: $

CHECK ONE. WHICH TYPE OF PAYMENT ARE YOU SEEKING?

❑ Reimbursement for an item/service that has already been purchased.

❑ Direct payment to a vendor for an item/service that has NOT already been purchased.

List item(s) you are requesting funding or reimbursement for:

Describe how your medical condition relates to a need for this technology.

CHECK ONE. THIS TECHNOLOGY WILL BE USED MAINLY FOR:

❑ **EDUCATION/COMMUNICATION**

❑ **OVERALL QUALITY OF LIFE**

Explain how this device will be used and how it will contribute to either your education/ability to communicate OR overall quality of life. Please list any apps you will be using for educational/communication purposes.

Section C: Disclosure/Signature

I declare that the information provided on this application for financial assistance is true and complete to the best of my knowledge. I understand that what I submit to Jake's Help from Heaven is for the purpose of financial reimbursement for or direct purchase of medically necessary or convenient items. I understand that I may be required to provide additional evidence of submitted information and I give permission to Jake's Help from Heaven to contact the medical facility for verification purposes. I agree to allow Jake's Help from Heaven to use my name in announcements and related publications.

Signature of Applicant or Parent/Guardian:

Printed name of Applicant or Parent/Guardian:

Date:

Signature of social worker or primary doctor:

Printed name of social worker or primary doctor:

Contact number:

Date:

ATTENTION!

BEFORE SUBMITTING YOUR APPLICATION, PLEASE ENSURE YOU HAVE PROVIDED THE FOLLOWING REQUIREMENTS AND HAVE PLACED A CHECK NEXT TO EACH SUBMITTED ITEM. APPLICATIONS WILL OTHERWISE BE CONSIDERED INCOMPLETE AND WILL NOT BE REVIEWED.

❑ Completed application with signature of pediatrician/primary care doctor or social worker

❑ Doctor's prescription and/or letter of medical necessity

❑ Receipts of purchased items OR vendor information for item to be paid directly by Jake's Help from Heaven

***In the event that you receive your requested item elsewhere, please alert us immediately so that we can withdraw your application. Failure to do so may affect your eligibility to apply in the future. ***