Jake's Help from Heaven General Grant Application

Jake's Help from Heaven, founded in 2011, is a non-profit dedicated to providing opportunities for those with medical challenges and disabilities to THRIVE.

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.

AS OF 2024, INCOMPLETE APPLICATIONS WILL NOT BE SUBMITTED TO THE BOARD OF DIRECTORS FOR CONSIDERATION. THE FOLLOWING CRITERIA MUST BE MET:

- Completion of the following application with the signature of a pediatrician/primary care doctor or social worker.
- A doctor's prescription and/or a professional letter of medical necessity by a doctor, therapist, or teacher. 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.
- To be eligible for reimbursement, items and services must have been purchased within one year of the date the application is being reviewed.
- 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.
- If 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.

IN ADDITION, PLEASE NOTE THE FOLLOWING POLICY CHANGES:

- If the primary letter of medical necessity was written by the individual or practice providing the requested service, we require a second letter or script from a disinterested medical provider.
- Please be precise when providing product information. JHFH is not responsible for returning/exchanging incorrect items that resulted from a mistaken request.
- Please double-check that the applicant's address is listed correctly. JHFH is not responsible for replacing items mailed to the wrong address due to errors on the application.
- Applicants requesting a grant of over $1,000 may be asked to submit a current income tax return or other financial information.
- When individuals other than the applicant are completing the application, please write in the third person and do not write in the applicant's voice.

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:

Section B: Application Details

Grant amount request: $ _____

WHICH TYPE OF PAYMENT ARE YOU SEEKING? CHECK ONE.

❑ 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.

Describe your medical condition and the hardships it creates.

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

Describe the item. How does your medical condition relate to the need for this item?

How do you expect to use this item (for what purpose, how often, where etc.)

In what ways will this contribute to an increased quality of life for the applicant and family?

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 and services. I understand that I may be required to provide additional evidence of submitted information, including a current income tax return or other financial information. I give permission to Jake's Help from Heaven to contact the provided 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, primary doctor, or care worker:

Printed name of social worker, primary doctor, or care worker:

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, social worker, or care worker.

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

❑ Receipts of purchased items OR vendor information for items 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. ***