Pediatric Spine Foundation

GRANT APPLICATION

FAMILY MEDICAL ACCESS FOR PEDIATRIC SPINE CARE

Instructions
To apply for medical access funding, please complete the application form, attach any additional required materials and e-mail to the PSF Support Team: support@pediatricspine.org.

General Guidelines

- Applications for funding need to be related to travel required for pediatric spine care.
  - Funds can support travel for patient and one caregiver.
  - Funds can be used to support car and/or air travel and lodging fees.
  - Funds cannot be used to reimburse the cost of clinical care.
- Applicants are required to demonstrate financial need. Applicants may be required to provide documentation supporting this need.
- Applications need to provide evidence that a care pathway has been determined.
- Funds are for planned medical trips that have been approved by the Evaluation Committee, not for treatment that has already been completed.
- All correspondence will be sent to the primary applicant. It is the responsibility of the primary applicant to provide all receipts and documentation to the PSF Support Team.
- Applicants can request for funding multiple times.

Selection Process
Grant applications are reviewed by the Evaluation Committee of the Pediatric Spine Foundation. Applications are reviewed on the basis of their financial need and their relation to pediatric spine care.

All persons submitting an application do so with the understanding that they will abide by the conditions, policies, and decisions of the Committee.

Statement of Conditions
It is understood that any funding approved by the Pediatric Spine Foundation will be made on the following conditions:

- Applicant will submit estimated expenses, including any electronic estimates, communication with institution regarding lodging fees, and any other support documentation for review with the application.
- The Foundation will approve the estimate and provide funding following completion of the trip, with appropriate receipts provided.
- The amount of the award will be expended for the support of the person and purpose described in the application and none of the funds will be diverted to any other expenses. The applicant will immediately notify the Foundation if support for the same person or purpose is received from other sources, in which case, the award will terminate and the balance will be returned to the Foundation.
- A report detailing expenditures including copies of all receipts will be furnished to the Executive Director within 7 days after completion of the trip for reimbursement.

Publicity
As a recipient of the Medical Family Grant sponsored by the Pediatric Spine Foundation, you will be asked to sign a publicity release form. You are under no obligation to do so. These pictures will be used to secure additional funding to support other families in need. If you consent, please send pictures to the PSF Team. These pictures can include candid pictures of your family, radiographs, and any clinical pictures.

Grant Application

Patient Name: _____ _____ DOB: _____
(last) *(first)* *(m / d / yy)*

Parent/Legal Guardian Name: _____ _____
(last) *(first)*

City, State: _____ Telephone: _____

Email: _____

Referral Source
Physician Name : _____

Institution: _____ Telephone: _____

Attach:
☐ Brief medical history including diagnosis, current needs, past treatments, etc.
☐ Copy of most recent full spine xray (AP/lateral)
☐ Copy of supporting medical records

Annual Household Income: $_____ /yr Number of People in Household: _____

Statement of Understanding and Authorization

I have read, understood, and agree to abide by the statement of conditions and guidelines provided by the Pediatric Spine Foundation for the Family Medical Access for Pediatric Spine Care grant application. I certify that all information provided in the grant application is accurate. I authorize the Pediatric Spine Foundation to discuss and share medical information provided with participating Foundation reviewers and referral source for the purposes of evaluation.

Printed name of Applicant: _____ Signature of Applicant: _____

Date: _____

Promotion Consent

I hereby give my consent to the Pediatric Spine Foundation (PSF) to use my (child's) name, photograph, story and statements, and medical information, such as diagnosis and treatment, in any promotional materials (printed or electronic). I understand that my (child's) name, photographs and/or video images may be used in a publication, print ad, direct-mail piece, electronic media, or any other form of promotion. I release the PSF, the photographer, their offices, employees, agents, and designees from liability for any violations of any personal or proprietary right I may have in connection with such use.

☐ I have read and understood this consent and release.

Child's Printed Name: _____ Child's Signature (if able): _____

☐ I certify that I am a custodial parent and have the aforementioned rights to assign.

Parent/Guardian Printed Name: _____ Parent/ Guardian Signature: _____

Date: _____

Pediatric Spine Foundation
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