THE BRIANNA FUND FOR CHILDREN WITH PHYSICAL DISABILITIES, INC.

Information and Application Packet

Welcome to the Brianna Fund for Children with Physical Disabilities, Inc. We have developed this information and application packet to assist you in the process of applying for a grant from the Brianna Fund. This application along with a personal interview will be used to determine your eligibility to receive assistance from the Brianna Fund. The support provided may be monetary, resource identification and/or linkage to appropriate services (**monetary awards are not always possible**). Awards may be in the form of mini grants as well as matching funds grants.

Mission and Purpose of the Brianna Fund:

The Brianna Fund was founded in October 1998 to assist children with physical disabilities by eliminating barriers of access to community resources. By providing necessary resources to solve pressing mobility issues, children with physical disabilities can enhance their capacity for living a full and productive life, and able to participate in all aspects of community life.

Who Makes Up The Brianna Fund?

The Brianna Fund is made up of a dedicated group of people who, in cooperation with others, want to create genuine opportunities for children with physical disabilities. We are committed to assuring that there are resources for children to grow up with physical, emotional, and social independence.

Who Is Eligible To Receive Funding Assistance?

The families of children from birth to 22 years of age that have a physical disability, which specifically relates to mobility and access.

How Will The Funds Be Administered?

The Brianna Fund is operated under the auspices of the Community Foundation of Western Massachusetts. The Community Foundation will assist the Brianna Fund in administering funds to children/families in the Greater Springfield area.

Application Deadline:

Applications are available beginning in October and can be picked up at these designated locations (**Dora, add names of pick-up locations**). The **deadline for applications is the first Monday in December.**

All completed applications should be returned (by mail) to The Brianna Fund for Children with Physical Disabilities, Inc., P.O. Box 1702, Springfield, MA 0ll01.

Process For Applying To The Brianna Fund:

The attached application must be completed in its entirety with questions fully answered. All appropriate requested documentation must accompany your application.

Your application will be reviewed by a committee and given prioritization based upon need and availability of funds. A reviewer will come to your residence to personally interview you to assure that all necessary information is collected for processing your application. A determination will be made by the second (2nd) week in January.

The motto of the Brianna Fund for Children with Physical Disabilities, Inc. is

"A HAND UP – NOT A HAND OUT"

It is the expectation of the Board of Directors of the Brianna Fund that award recipients as well as their family and friends will support the fundraising efforts of the Brianna Fund by:

1. Attending event committee meetings to plan and implement annual fundraisers.

2. Soliciting donations, pledges, and/or contributions from friends and family members.

3. Providing support to fundraising activities with your time, energy and commitment.

The Brianna Fund has four (4) major fundraising events yearly, which take place between the months of October and June.

l. Annual kick-off event in October

2. MLK Jr. Gospel Celebration in January (Dr. King's birthday weekend)

3. Winter Gala (silent & live auction/black tie affair) in February

4. Presentation of award to family

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APPLICATION REQUEST

Date application received:________________ Assigned to:________________________

Name of Child____

Date of Birth:__________________ { Female { Male Ethnicity:_______________

Name of Parent(s)/Legal Guardian:____

Address:____

Phone (home):__________________________ (work):____________________________

List other occupants living in the home:

____ ___________________________________

_______________________________________ ___________________________________

Is this child a resident of Massachusetts? { Yes { No
Is this child a resident of Springfield? { Yes { No

Person providing information:__________________Relation to Child:______________________

Phone Number:__________________________________

Program or school presently attending:________________________________ Grade:_____

School Address:__________________________________ Phone Number:_________________

Describe your child's specific mobility limitation(s), and physical disability(ies). Is this a long-term (permanent) or short-term (temporary) disability?

____

____

____

What diagnosis has been used to describe the child's condition?_________________________

____

Does the child use a mobility aid (wheelchair, cane, walker, etc.?) { Yes { No

If yes, please describe which mobility aid:____

What types of services or supports are requested or needed for the child?

{ Assistive Technology
{ Communication Supports
{ Home Health Care
{ Respite
{ Educational Advocacy
{ Camp
{ Mobility Assessment
{ Medical/Health Services
{ Recreational Supports
{ Parent/Caregiver Training
{ Transportation
{ Adaptive Equipment
{ Adaptive Resources
{ Adaptive Assessment

Please check if the child is receiving any of the services listed below:

{ Medicaid { Medicare { Commonhealth { Kaileigh Mulligan

What are the child's sources of economic security?

{ SSI, SSDI { Public Assistance { Family { Other:___________

Does the child receive services from any of the agencies listed below? { Yes { No

AGENCY	SERVICE	CONTACT PERSON
Department of Mental Retardation	____________________	______________________
Department of Social Services	____________________	______________________
MA Commission for the Blind	____________________	______________________
Department of Public Health	____________________	______________________
MA Rehabilitation Commission	____________________	______________________
Department of Education (766)		
Special Education	____________________	______________________
Other(s)	____________________	______________________
	____________________	______________________

Please attach to your application no more than a one (1) page Statement of Need describing how this request for assistance will enhance the quality of life for this child on a long-term basis.

As the parent/legal guardian of this child, I attest that the information provided is true and accurate regarding this child's physical/mobility limitation. If my child receives assistance from the Brianna Fund, I understand that I will be expected to commit to working with the committee to raise funds for the Brianna Fund events calendar year. I will ask five of my family members and/or friends to make this commitment with me. We will be asked to solicit donations, pledges and contributions to support the work of the Brianna Fund.

____ ________________________

Signature of Parent(s)/Legal Guardian Date

Additional Information:

Child's primary physician:____

Address:____

Health Insurance:____

Other supplemental insurance:____

Documentation of Physical Disability:

Specific documentation of physical disability must be provided. This information shall include, but not be limited to, a letter from a physician; a recent educational evaluation; a current Individual Education Plan, Individual Family Service Plan, Individual Support Plan. An eligibility determination will not be made solely on the basis of information contained in an IEP, IFSP, or ISP.

Please have your child's primary physician sign that this request for assistance as it relates to accessibility issues is appropriate for this child's mobility limitations.

Physician's Signature:____

Date:____