Cerebral Palsy Awareness Transition Hope
GRANT PROGRAM
Information and Application Packet

CPATH is a Central Texas non-profit created to support individuals and families within the cerebral palsy community. The CPATH Grant Program is established as a form of financial assistance for families of children and individuals diagnosed with cerebral palsy who are in need of medical equipment/devices, therapy and recreation support.

Eligibility Criteria

- Central Texas Resident
- Guardian of or individual diagnosed with cerebral palsy

Grant Details:

- $500 per medical grant maximum
- Items considered for this grant include but are not limited to medical equipment, bathing, seating, transport, therapy tools, therapy, camps and recreation.
- Grants will be reviewed quarterly by the Board of Directors.
- Grants will be awarded either as reimbursement for purchase (must provide a receipt) or paid directly to vendor.
- Funding is not guaranteed until you have received formal funding approval in writing.

We thank you for your interest in the CPATH's Grant Program and look forward to the possibility of working with you. If you have any questions about this program, the application process or any other CPATH program, please feel free to contact us directly.

Sincerely,

Victoria Polega
President - Board of Directors
CPATH Cerebral Palsy Awareness Transition Hope
5501A Balcones Drive, #160
Austin, Texas 78731
Phone: 866-742-7284
victoria@cpathtexas.org

CEREBRAL PALSY AWARENESS TRANSITION HOPE

Grant Program
Application Instructions and Checklist

INSTRUCTIONS:

- Please type or print in blue or black ink.
- Fully complete all sections and forms of the application.
- CPATH will accept application through email postal mail, or in person.
- For assistance, please contact 866-742-7284 or by email at victoria@cpathtexas.org

COMPLETED APPLICATION INCLUDES THE FOLLOWING:

- ☐ Preparer's Statement
- ☐ CPATH Application pages 1 - 3
- ☐ Medical Eligibility Form- Completed by a healthcare professional
- ☐ Authorization For Release of Medical Records and Provider Letter
- ☐ Liability Release
- ☐ Equipment specification and/or bid from supplier or clinic explaining what service or piece of equipment is being requested along with a price estimate.
- ☐ Any supplemental attachments or additional information.

Please mail applications including all documents to the address below. Incomplete applications are subject to delay.

Please return entire application and supplemental information to:
CPATH Cerebral Palsy Awareness Transition Hope
5501A Balcones Drive, #160
Austin, Texas 78731

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Preparer's Statement

Applicant's Information	
Name	Phone (daytime)
Date of Application	Phone (evening)
Home Address	City, State, Zip

If application is prepared by someone other than Applicant:	
Name	Phone (daytime)
Relationship to Applicant	Phone (evening)
Email Address	Cell Phone
Home Address	City, State & Zip

Legal Guardian(s) Assurance
I/We stipulate that the information included in this application is true to the best of my/our knowledge and abilities. Further, I/we understand that the presence of inaccurate information in this application could result in re-evaluation or rejection of this application by CPATH.

Legal Guardian's Printed Name _____

Legal Guardian's Signature _____Date (mm/dd/yy) _____

Legal Guardian's Printed Name _____

Legal Guardian's Signature _____Date (mm/dd/yy) _____

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Grant Application

Recipient Information		
Name	Date of Birth (m/d/yy)	Current Age
Address of Residence (including City, State and Zip Code)		
County of Residence		
Daytime Phone Number	Evening Phone Number	Cell Phone
Number of Siblings (if any):	Ages of Siblings:	
Legal Guardian Name:	Legal Guardian Name:	

Medical Information
Has the applicant or sibling received a cerebral palsy diagnosis? **Yes / No**
Describe the nature of disability or need for assistance (i.e. child's medical condition)

Prior Applications
Has the applicant or his/her family applied for assistance from CPATH in the past two years?
Y / N If yes, Please explain

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Funding Request		
Amount of funding requested	$	If CPATH is unable to fulfill the entire request, is partial funding an option? Yes / No
Describe the funding request in detail (you may attach additional pages):		
If funding request is granted, please describe how it will impact the recipient's life		

Other Funding
Has applicant or applicant's family requested or received support from other sources, ie legal action, charitable organizations, scholarships, etc YES / NO
If yes, please provide details (including agency, amount, date)

Supplemental Information
Please include any additional information that might clarify your child's need for the request and/or the inability to obtain these items through an insurance provider or other resources. You may attach additional pages and photographs, if necessary.

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Medical Eligibility Form

*The purpose of **CPATH** Cerebral Palsy Awareness Transition Hope, a 501 (c)(3) nonprofit charitable organization, is to provide resources, support, and financial assistance to families and individuals living with cerebral palsy, while building community awareness and acceptance for all.*

The individual, or guardian of the person listed below has requested consideration for the CPATH grant program, which provides grants to offset the costs of therapy, equipment, and recreation programs to enhance the lives of individuals with cerebral palsy or their families.

Instructions
This medical eligibility form must be completed by an authorized health care professional who has direct knowledge of the individual or family applying for the grant. Authorized health care professionals include licensed doctors of medicine, certified nurse practitioners, social workers, physical, occupational, or speech therapists. Please return this form with the application or mail it separately to: CPATH Cerebral Palsy Awareness Transition Hope 5501A Balcones Drive, #160 Email: Victoria@cpathtexas.org Austin, Texas 78731 Phone: 866-742-7284

Eligible Child Information	
Name:	Birthdate:
Parent/Legal Guardian:	Primary Diagnosis
Physician:	

Eligibility Determination
I work directly with individuals with cerebral palsy. _____ Individual is eligible. _____ Individual is not eligible due to inability to confirm medical condition or is not medically eligible at this time.

Authorized Health Care Professional's Signature:_____

Title:_____ Date:_____

Phone Number:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

As part of the evaluation of each applicant's grant application, it may be necessary for CPATH to investigate and verify the applicant's diagnosis, treatment, and other information contained in the patient's medical record. As such, we require all applicants to grant authorization to CPATH to obtain copies of their medical record and discuss these matters with any of applicant's health care providers. We will seek to obtain this information from the provider whose name and information you list below; however, by your signature, you consent to our contacting any physician or other health care or therapy provider who has provided care to applicant in the past and whose name is contained in the patient's medical record.

CPATH will use your information solely to evaluate your application and the expenses for which you have requested a grant. However, CPATH also requests your consent to use such information in its own fundraising activities. Successful fundraising is essential to our ability to make future grants like the one you have applied for. Past experience has shown that our fundraising appeals are more successful when we are able to include the stories and photographs of actual cerebral palsy patients.

Please indicate whether you consent to the use of identifying information or other personal health information in our fundraising activities below (**CHECK ONLY ONE)**:

☐ I consent to the use of my full / first (circle one) name and a photograph, videorecording or other likeness of me in CPATH's fundraising activities, including, but not limited to, pamphlets, brochures, meetings, presentations, website and social media.

☐ I consent to the use of my full / first (circle one) name in CPATH's fundraising activities, including, but not limited to, pamphlets, brochures, meetings, presentations, website and social media. However, I DO NOT consent to the use of any likeness of me, including photographs or videorecordings.

☐ I DO NOT consent to the use of my name or any likeness of me in CPATH's fundraising activities. (A description of your story and your use of CPATH funds may still be included; however, it will be done in such a way that you are not identified or identifiable.)

Any health records collected by CPATH or in CPATH's possession shall be destroyed or returned at the end of the calendar year in which you received the grant, unless you renew your application for a grant. However, CPATH may continue to use your name and/or likeness (depending on the consent given above) until such time as you withdraw such consent in writing.

For purposes of this authorization, CPATH includes CPATH's officers, directors, employees and agents.

Write name, address and telephone number of physician or other health care provider to whom this form should be sent:

Physician/ Health Care Provider's Name:_____

Address:_____

Phone Number:_____

Applicant Name: _____Date:_____

Signature:_____

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Dear Provider:

This letter is intended to let you know that _____ has submitted an application for a charitable grant from Cerebral Palsy Awareness Transition Hope (CPATH). CPATH funds can be used to defray the costs of a multitude of needs that cerebral palsy patients and their families routinely incur when dealing with and treating their condition. As part of the application process, CPATH may need to review the applicant's diagnosis, medical records, and/or discuss with you the patient's medical history, treatment and needs.

The signature of the Applicant below (or their guardian where applicable) constitutes their authorization for you to share protected health information, including copies of the Applicant's medical record, with CPATH for these purposes. Please note that the Applicant's protected health information will be used only (i) to evaluate the Applicant's application and requested expenses and (ii) where Applicant has granted his or her specific consent, for CPATH's fundraising activities. CPATH will not publicize, disclose or disseminate protected health information for any other purpose. An Applicant's protected health information will be destroyed at the end of the calendar year in which the Applicant received a grant unless the Applicant renews their grant application for another year.

_____
Patient/guardian name

_____
If guardian has submitted application, patient name

_____
Patient/guardian signature

_____
Patient Date of Birth

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LIABILITY RELEASE

By submitting the attached application and by his or her signature below, the applicant acknowledges the following:

- For purposes of the items below, "CPATH" shall include CPATH, its officers, directors, employees and agents.

- Other than the grant provided pursuant to an approved application (maximum value: $500), CPATH shall have no other liability or obligation to the applicant or any family member, or guardian. **UNDER NO CIRCUMSTANCES SHALL CPATH'S LIABILITY TO THE APPLICANT, HIS OR HER FAMILY MEMBER(S) OR GUARDIAN(S) EXCEED THE TOTAL AMOUNT OF THE GRANT PROVIDED TO THE APPLICANT.**

- Applicant is solely responsible for his or her use of the funds provided through this grant. CPATH shall have no responsibility or liability to any vendor, health care provider or other third party for any costs or expenses incurred by applicant, any family member or guardian.

- CPATH has provided no recommendations to Applicant, his or her family member(s) or guardian(s) regarding specific health care or therapy providers, diagnoses, or treatments, and CPATH is not responsible for Applicant's choice of health care or therapy provider, the care provided through such professional or entity, any diagnosis or misdiagnosis, any course of treatment or lack thereof, or any other act or omission of Applicant's health care or therapy provider(s). As between CPATH and the provider(s), any malpractice by any health care or therapy provider is the sole and exclusive responsibility of the provider(s), even if CPATH grant funds are used to pay for the care.

- CPATH is not responsible for any claims associated with items or services purchased with CPATH grant funds. By way of example and not limitation, if Applicant uses CPATH grant funds to purchase medical or therapy equipment and Applicant suffers an injury because of a malfunction or defect in the equipment, CPATH shall have no responsibility or liability associated with such equipment, its use or quality.

Signature_____

Applicant Name: _____

Date:_____