Busby Foundation Assistance Application

A. Applicant Information

First Name	Last Name	Approval? **Association** ☐ **Busby Rep** ☐ **Committee** ☐
City	State	Date of Birth
Assistance Requested (please provide a detailed description of what is needed)		
Estimated Cost	**Maximum Amount Approved**	

Diagnosis (please include the date of diagnosis and brief description of current symptoms):

B. Primary Correspondent

Name	Relationship to applicant
City	
State	

C. Family Members

Name / Location	Relationship	Age
Name / Location	Relationship	Age
Name / Location	Relationship	Age

D. Financial Information

Income Source: (Employment, SSDI, Etc.)	**Amount Received per Month:**	**Resources Exhausted:**
		☐ **Private Insurance**
		☐ **Medicare**
		☐ **DARS**
		☐ **VA**
		☐ **Architectural Barrier Removal**
Total: $		☐ **Loan Closet**

E. Release

Yes or No (Check one box)

Applicant consents to disclosure of application information to Busby Foundation board members and affiliates

F. Marketing Support

Yes or No (Check one box)

If we are awarded a grant support from the Busby Foundation, we would be able to offer a testimonial or other marketing support to show how the Busby Foundation has assisted our family.

_____ _____

Applicant / Representative E-Signature **Date**

G. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
	1.	1.
	2.	2.

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted
Date: Initials:	Date: Initials:	Date: Initials:	Date: Initials:	Date: Initials:

* Please attach any relevant bids, specifications, invoices, evaluations, etc.

H. Other Information

Please provide any other relevant information and/or photos

Association Signature **Date**

Busby Foundation Signature **Date**