Stroke Survivor Fund

Hello,

Thank you for your interest in applying for the Stroke Survivor Fund grant from The Stroke Foundation.

Founded in 2020, The Stroke Foundation non-for-profit 501(c)3 (EIN 84-4179502) foundation empowers stroke survivors during their recovery and rehabilitation phase by providing grants for additional physical, occupational and speech therapy.

To be eligible for the grant, you must meet the following guidelines:

- Be a stroke survivor of at least 21 years of age and reside in the USA.
- Demonstrate financial need or hardship.
- Demonstrate health insurance benefits related to physical, occupational and/or speech therapy have run out.
- Provide a personal statement detailing why you should receive the grant.
- Provide proof of diagnosis by a medical professional.
- Provide proof of necessary treatment plan for physical, occupational and/or speech therapy provided by a medical facility.

Our Board of Directors will review and assign grants to individuals in accordance with our guidelines and policies, and on a case-by-case basis. Applications are reviewed and grants are distributed at the discretion of The Stroke Foundation.

The Stroke Foundation will notify grant recipients via email within 60 days of the application deadline.

If you have any questions, please email survivorfund@thestrokefoundation.org.

Thank you again for your interest.
The Stroke Foundation Team

The Stroke Foundation

Stroke Survivor Fund

Personal Statement

Please provide us with a statement on why you should receive this grant.

I hereby certify all information on this page is accurate and truthful.

Printed Name _____ Signature _____ Date _____

Stroke Survivor Fund

Personal Information

First Name _____ Middle Name _____

Last Name _____ Date of birth _____

Phone number _____ Email _____

Mailing address _____

If you are a caregiver applying on behalf of a stroke survivor, please fill out the following information:

First Name _____ Middle Name _____

Last Name _____ Date of birth _____

Phone number _____ Email _____

Mailing address _____

Demographic Information

Sex ☐ Male ☐ Female ☐ Prefer not to disclose

Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to disclose

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose

I hereby certify all information on this page is accurate and truthful.

Printed Name _____ Signature _____ Date _____

Stroke Survivor Fund

Terms, Conditions and Consent

Please initial each individual line and sign at the bottom.

____ I certify the primary applicant (patient) has been diagnosed with a stroke.

____ I certify the primary applicant (patient) is over 21 years old and resides in The United States.

____ I have included in this application an Explanation of Benefits (EOB) from my health insurance provider stating that benefits for physical, occupational or behavioral therapy has run out.

____ I have included in this application a personal letter stating why I am applying for this grant.

____ I have included in this application a letter from a medical professional confirming the primary applicant's diagnosis.

____ I have included in this application proof of income (W-2 or most recent tax return) or a document that demonstrates financial hardship.

____ I understand The Stroke Foundation reserves the right to choose who receives the grant, the amount of funds dispersed, and when the funds are paid out.

____ I understand The Stroke Foundation will only use the information I provide in this application to make a decision on the grant, and will not use my information for any other purpose.

____ I understand the funds granted will be paid directly to the facility providing therapy and I (the patient and/or caregiver) are responsible for ensuring funds are appropriately used.

____ I understand The Stroke Foundation is not liable or responsible for events including, but not limited to, ensuring the funds are appropriately used, the quality or quantity of therapy received, the outcome of the therapy, or any medical treatment received before, during or after the grant is paid out.

____ I consent to the information I have included in this application to be used for the purpose of determining my eligibility for the grant.

____ I consent to The Stroke Foundation to contact the primary applicant, caregiver and/or the medical facility providing treatment to confirm details included in this application.

I hereby certify all information on this page is accurate and truthful.

Printed Name _____ Signature _____ Date _____