



# Grant Application

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Individual this request will benefit: \_\_\_\_\_ Age of Individual: \_\_\_\_\_

Individual's Diagnosis: \_\_\_\_\_

**\*\*Please attach documentation supplied from the Individual's doctor pertaining to diagnosis.**

Item being requested: \_\_\_\_\_

Have you tried to secure funding through the Individual's insurance company? Yes  No

Is the Individual enrolled in Medicare or Medicaid? Yes  No

Is the Individual enrolled in MHDS? Yes  No

**\*\* If yes to any of the above, please attach denial letter to this document.**

To what other organizations is the Individual aligned? \_\_\_\_\_

Have you attempted to get the requested item from any of the organizations listed? Yes  No

**\*\* If yes, please provide denial letter.**

Does a physician believe this item could help the Individual? Yes  No

**\*\* If yes, please provide a note from the physician. If no, please describe on the back of this form why you think this item will help.**

The above information is correct to the best of my knowledge. Shall the donation be approved, I will use the donated item for the purpose listed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## OFFICE USE ONLY

Approved  \_\_\_\_\_ Item Cost: \_\_\_\_\_  
Signature

Denied

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