



**WHEELS WITH WINGS FOUNDATION
INDIVIDUAL GRANT APPLICATION**

Name _____ Social Security Number _____

Date of birth _____ Birth city _____
(Please attached a photocopy of birth certificate, US Passport or valid driver's license)

Address _____

City _____ State _____ Zip code _____

Home phone _____ Cell _____

Email address _____

Date of Injury _____ Level of Injury _____

Cause of Injury _____

Marital Status _____ Children _____ Ages _____

Are you employed _____ If so, name of Employer _____

Primary Insurance _____ Secondary Insurance _____

Were you injured on the job ___ If so, are you collecting workers compensation _____

Name of workers compensation carrier _____

Contact information for workers compensation carrier _____

What was your occupation prior to your injury _____

What is your level of education _____

What is your current living situation (i.e. on your own, with parents) _____

What is your current monthly income from all sources: _____ Please submit
proof of such income. (SSI, SSDI, W2, tax return) _____

How did you hear about the Wheels With Wings Foundation?

Please describe the degree of your disability and how it affects your everyday life:

Other factors that you may wish to be taken into consideration (health factors, living arrangements, financial or family issues etc.):

Give a detailed description of the services and/or equipment or modification(s) for which you are applying, including the provider's names, manufacturer's name, model numbers etc. if applicable:

Give a brief description of how the services and/or equipment or modification(s) for which you are applying would impact your daily life:

Please provide the names, addresses and phone numbers of at least (3) providers and/or contractors you have contact and their prescribed treatment with potential outcomes and estimates for equipment or modifications requested Please attach any written quotes, if any, you have received: *Materials submitted are non-returnable.*

Therapist/Rehabilitation Facility or Provider

Contact Name

Address

City, State, Zipcode

Phone No.

Web address (if any)

Quote

Therapist/Rehabilitation Facility or Provider

Contact Name

Address

City, State, Zipcode

Phone No.

Web address (if any)

Quote

Therapist/Rehabilitation Facility or Provider

Contact Name

Address

City, State, Zipcode

Phone No.

Web address (if any)

Quote

Additional comments _____

In order to be considered for the Wheels With Wings Foundation Quality of Life Grant, applicants must provide estimates for the cost of services and/or equipment or modifications requested.

Print, sign and return the attached checklist along with all the necessary documentation requested in the grant application.

Incomplete applications will not be considered.

I certify that, to the best of my knowledge and ability, the information included in this application is accurate as of the date signed below. By my signing this application, I give permission to the Wheels With Wings Foundation to obtain medical records related to my injury and to the therapy I have done. I also acknowledge that I am aware if I receive a Wheels With Wings Foundation Quality of Life Grant, my name/image may be used by the Wheels With Wings Foundation for media and/or promotional purposes:

Signature of Applicant: _____ **Date:** _____

Signature of person filling out on applicants behalf: _____

Relationship: _____

Mail completed applications to:

Wheels With Wings Foundation, Inc.
ATTN: Mary Lynn Barnhard, Foundation Coordinator
P. O. Box 975
Cheektowaga, New York 14225





Rising above spinal cord injuries

**WHEELS WITH WINGS FOUNDATION
QUALITY OF LIFE GRANT CHECKLIST**

Please print this checklist, sign and date and return with completed application. Be sure to include all documentation as incomplete applications will not be considered.

- Completed Grant Application**
- Birth certificate, US Passport, or valid driver's license**
- Physician letter indicating level of injury and diagnosis**
- Proof of income, i.e. SSI, SSDI, W2, tax return**
- Three (3) quotes**
- Denial letters from insurance or other sources for grant request**

Signature of Applicant: _____ **Date:** _____

Signature of person filling out on applicants behalf: _____

Relationship: _____

Grant application and all submitted documents are for the sole use of the Wheels With Wings Foundation Grant Committee for the purpose of awarding Quality of Life Grants and will be kept strictly confidential.