Mary and Charles A. Parkhill Foundation
For Spinal Cord Rehabilitation

GRANT APPLICATION FORM

Please complete the application and send it via fax or email to:

Fax: 248-322-5447 Email: MACAPF@aol.com

After your application is reviewed, our office will contact you by email or phone. The completion of this application does not guarantee a grant for therapy. All information will be kept confidential.

CONTACT INFORMATION

Name:_____

Address:_____City:_____

State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ Email :_____

PERSONAL INFORMATION

Date of Birth:_____ Height:_____ Weight:_____

Sex:____ Level of Spinal Cord Injury_____ ASIA Level/Score (If known) _____

Complete or Incomplete Diagnosis:_____ Date of Injury:_____

How were you injured:_____

At what hospital were your treated?_____

Treating Physician:_____

Current Physician:_____ Date of Last Medical Exam:_____

Past surgeries:_____

Medications:_____

Describe present support systems (family, caregivers, etc.)_____

In case of emergency, please notify:

Name:_____ Relationship:_____

Phone (home):_____ Phone (work):_____

Describe your physical abilities (Be as specific as possible, particularly with respect to your legs):

Upper Extremities:_____
_____
_____
_____

Trunk (IE: Can you sit up?)
_____
_____
_____

Lower Extremities:_____
_____
_____

Please list any physical problems or special considerations (IE: osteoporosis/osteopenia, knee instability, obesity, hypersensitivity, rods in back, other health issues):
_____
_____
_____

Previous rehabilitation (if any):
_____

Date last attended:_____ Results:
_____
_____

Medical Insurance:_____

Physical Therapy benefits:_____

Grant applications are considered for individuals that have no therapy benefits available from insurers (including Medicare) and are without personal resources to pay for therapy – please note the highlighted section from our mission statement:

While scientists, doctors and researchers around the world seek a cure for spinal cord and other neurological injuries, the responsibility of high intensity rehabilitation therapists is to keep those of us with SCI/TBI healthy and fit until a cure is found, or in a lifetime of fitness.

Unfortunately, there are injured individuals without the healthcare benefits or private resources required for ongoing therapy and exercise.

The mission of The Mary and Charles A. Parkhill Foundation for Spinal Cord Rehabilitation is to raise funds that will be granted to those individuals, in the form of scholarships, to obtain therapy services.

Please describe your specific circumstances related to the availability of resources to fund physical therapy:

Insurance:

_____
_____
_____
_____

Personal Resources (including trust information):

_____
_____
_____
_____

Can you pay any portion of the cost of therapy ___ Yes ___ No

If yes, how much per month $ _____

Please tell us your goals and aspirations, what you hope to achieve from rehabilitation:

_____
_____
_____
_____

Why should you be considered for this grant:

_____
_____
_____
_____

Please add two letters of recommendation.

_____ _____
Signature Date

If under 18 years of age, name and signature of parent or guardian:

_____ _____
Print Name Relationship

_____ _____
Signature Date

By signing, I hereby certify all statements to be true. If found otherwise, I understand that all or portions of any grant can be forfeited.