BRAIN INJURY ASSOCIATION OF NEW YORK STATE

INTERAL TRACKING
___-202__

FAMILY FUND APPLICATION

The Brain Injury Association of New York State's Family Fund provides a onetime financial grant to improve the quality of life for an individual with a brain injury. Applications are reviewed on a rolling basis by committee, with a maximum approval of $400. Please complete the entire application and provide all necessary documentation for consideration.

Date of Request: _____

Name of Applicant: _____

Address: _____

City/State/Zip: _____ County: _____

Phone: _____ Email: _____

Is the applicant a BIANYS member? *(Please note that membership is required.)* Yes: _____ No: _____

If the applicant has applied to the Family Fund prior, please provide the date when: _____

Does the application receive services from: ___ DOH Medicaid TBI Waiver ___ OPWDD TBI Waiver

Name and Organization of
Person Completing Application: _____

Phone: _____ Email: _____

Relationship to Applicant: _____

FUND INFORMATION

Amount Requested*: _____ Date Needed: _____

Be sure to include proof of cost, including invoices and/or bills.

NARRATIVE

Please use a separate sheet to answer the following questions:

1. Statement of Need: what is needed and why.
2. Item information: based on the Statement of Need . . .
    a. Why is this the best solution to the need?
    b. Are there alternative solutions/items to the one you have outlined?
    c. Who is the vendor to be paid? Please include entire proof of cost and vendor contact information.
3. What other funding sources have been consulted? (Please note outcome)
4. What is the potential impact if funding is not approved?

Return this application and all supporting documentation, including invoices, name and address of vendor to be paid and additional information to be submitted with payment if approved, to:

Mail: BIANYS Family Fund, 5 Pine West Plaza, Suite 506, Albany, NY 12205
Fax: 518-482-5285 or Email: info@bianys.org

Incomplete applications will not be considered.