Samantha Goldsmith Fund

SAMANTHA GOLDSMITH FUND APPLICATION

The Samantha Goldsmith Fund will provide a one-time grant of up to $5,000 to assist brain injury survivors and their family in their time of need with unforeseen expenses related to the life changing events tied to brain injury.

Date of Request: _____

Name of Applicant: _____

Address: _____

City/State/Zip: _____ County: _____

Phone: _____ Email: _____

Name and Organization of
Person Completing Application: _____

Phone: _____ Email: _____

Relationship to Applicant: _____

FUND INFORMATION

Amount Requested*: _____ Date Needed: _____

STATEMENT OF NEED:

Please answer the following questions: Provide a narrative detailing the need and how the funds will be used. Be as detailed as possible.

1. Explain your need for funding.
2. Is this an emergency? If not, what is the timeline for funding?
3. What other funding sources have been consulted? (Please note outcome)
4. What is the potential impact if funding is not approved?

SUPPORTING DOCUMENTATION:

Please include the following attachments:

- Proof of New York State residency for the brain injury survivor or the immediate family members impacted by the funding
- Letter of support from a medical professional and/or health care system to verify injury and need
- Submission of other funding sources and/or insurances for review, or proof that insufficient time exists to obtain other funding in time of emergency
- Written estimate from a credited vendor detailing the project and cost, unless identified and verified as an emergency

Please include all supporting documentation, including invoices, name and address of vendor to be paid and additional information to be submitted with payment if approved. Incomplete applications will not be considered. Application should be submitted via email to info@bianys.org or mailed to BIANYS offices at 5 Pine West Plaza, Suite 506, Albany, NY 12205

I affirm that all information provided in this application and the accompanying documents are true and accurate to the best of my knowledge. My signature indicates that I authorize the Brain Injury Association of New York State to verify all information. I understand and acknowledge that false or misleading statements may subject the applicant to disqualification and/or repayment of any funds provided through the Samantha Goldsmith Fund.

Signature: _____ Date: _____

BRAIN INJURY ASSOCIATION OF NEW YORK STATE
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40 ANNIVERSARY 1982-2022