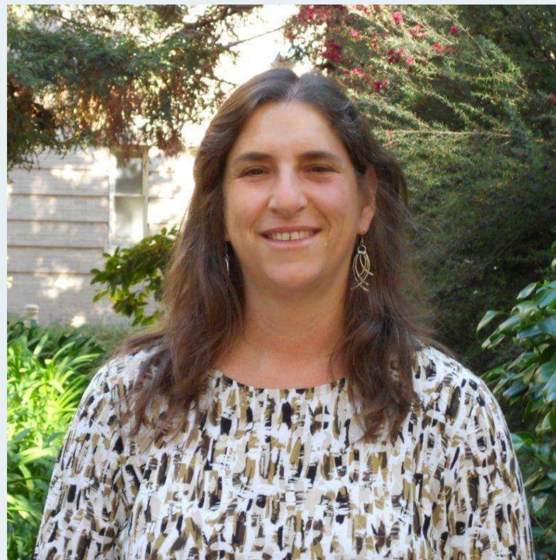
ARCH COMMUNITY FUND



LESLIE PRESTON MEDICAL HARDSHIP GRANTS AWARD PROGRAM

Application for Leslie Preston Medical Hardship Grants Award Program

Purpose	Grant of up to $2,500 in any 12-month period for organizes and activists who require assistance due to medical emergencies in connection with advanced cancer with terminal condition.
Eligibility requirements	▪ Activists or organizers whose work has been curtailed or are on disability due to advanced cancer with a physician's diagnosis; ▪ Volunteer, staff or board member affiliated with small grassroots organizations, especially Arch Community Fund grantees and; ▪ At least five years' experience in movement building and transformative organizing for the common good.
How to apply	Sections 1 - 3 should be filled out by the applicant. Section 4 should be completed by a health care provider who is familiar with the applicant's needs. (See that section for details.) Email the completed application form and physician's diagnosis to: hardshipgrants@archcommunityfund.org. Send questions to hardshipgrants@archcommunityfund.org which will be answered within one week.
Grants Decisions	Grants decisions will be made monthly.

Section 1 – General Applicant Information

Last Name ______________________ First Name______________________Middle Initial ______

Home Address____Apartment No. ______

City______________________________ State____________________ Zip______________________

Email____ Phone No ____________________

Non-profit affiliation______________________________________ Website ______________________

Contact Person ____________________Email ____________________ Phone No. ____________________

Your role in organization______________________________________ How many years______________

How did you find out about this program? ____

How many years have you been engaged in Movement Building and Transformative Organizing______________

Briefly describe your work and experience in Movement Building and Transformative Organizing______________

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Statement of Need. Please include a summary of your financial need, briefly explaining to us how your medical condition is creating financial hardship for you and/or your family.

I am applying for:

$500 _______ $1,000______ $1,500 _______ $2,000 _______ $2,500 _______ -

Section 2 – Information About the Medical Emergency or Nature of the Illness

Name of Applicant ____

Approximate Date of Medical Emergency or Diagnosis of Illness ____________

Briefly describe the nature of the illness or medical emergency and the circumstances supporting your request for assistance.

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Section 3 – Applicant's Declaration

I affirm that I meet the above described eligibility requirements for medical emergency assistance or relief from distress due to serious illness and that all the information I have provided to qualify for such assistance or relief is complete, correct, and true to the best of my knowledge. I understand that I may be denied assistance if any of the above is false, and that I may be required to repay any assistance that I receive based on false or incomplete information.

Upon request, I agree to provide Arch Community Fund "Arch"/"the Fund" or its Administrator with evidence of the information I have given on this application. I understand that this application becomes the property of Arch when submitted.

I understand that Arch's annual return is open to public inspection and that, if I receive a grant, Arch will be required by federal tax law to disclose on its annual return my identity and address, the grant amount, and a description of the grant purpose. I understand that, if I receive a grant, Arch will report on its annual return the address I provided above unless I provide my business address below to be used in place of my home address.

Business Address ____

Street Address, City, State, ZIP

SIGN HERE >_____________________________________DATE > ______________________________

Stop here – you have completed your part of this application.

Please make certain that Section 4 is completed by your treating physician or health care provider. This application will be rejected if the required referral is not completed and signed.

Return this completed application (Sections 1-3) and the physician's diagnosis (Section 4) to: hardshipgrants@archcomunnityfund.org.

This referral form must be completed and signed by the physician or health care provider treating the applicant. Please return this completed form to the patient.

Patient's name ____________________

Health care provider's name ____________________

Area of specialty & title ____________________

Facility's name (if applicable) ____________________

Address____________________

City, State and Zip ____________________

Phone ____________________

How long have you been treating the patient?__________Date of last examination __________

How many contacts have you had with the patient in the last six months? __________

Describe the patient's significant medical problems.

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Describe treatment and response.

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Additional comments.

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I affirm that all the information I have given above to assist the named applicant in qualifying for medical emergency assistance is complete, correct, and true to the best of my knowledge.

SIGN HERE >____________________DATE > __________

Health Care Provider's Signature

PRINT NAME >____________________