



THE KELLY PACKOWSKI MS FOUNDATION

GRANT PROCESS & GUIDELINES

MISSION STATEMENT

The Kelly Packowski MS Foundation's sole purpose is to provide direct support to individuals and their families from the New England area that are affected by Multiple Sclerosis. We are committed to helping make their daily lives more manageable both financially and emotionally. Each person with MS faces different challenges and we promise to address each individual's specific needs. By Changing One Life at a Time™, we will improve the quality of life for those individuals and their families battling Multiple Sclerosis.

PURPOSE

The Foundation's objective is to provide financial assistance to families that are facing hardship situations in meeting their day-to-day needs as a result of burdens from this disease. We want to ease the stress and concerns of those families by ***providing funding for home modifications, assistive devices, home health care, wellness programs, transportation, career counseling, child care and other basic needs.*** Note: we are unable to process requests for reimbursement of any medications, treatments (i.e. acupuncture, massages, etc.), physical therapy, security deposits or items that have already been purchased.

ELIGIBILITY

The Foundation is seeking New England based families that are suffering financial hardships as a result of the cost of caring for a family member with MS. *The family should identify specific needs that the Foundation can assist with and provide written estimates for any goods or services requested – applications will not be reviewed without this information.* When necessary, the Foundation will be pleased to work with the family to provide guidance on related services and assistance. We expect that grant recipients will be applying for assistance in obtaining products or services that they would otherwise have to forego if not for the Foundation's funding. *To assist as many families as possible, we are limiting grants to a maximum of \$1,500 per family per annum. The maximum number of grants per recipient is two per lifetime.*

ADVISORY BOARD

The program is administered by an Advisory Board led by Ms. Kelly Packowski. This Board will review all grant applications, select awardees, provide guidance to the awardees and ensure that the program meets its goals.

SUBMISSION & APPROVAL PROCESS

We request that all eligible participants submit the attached grant application, a letter from their attending physician confirming their situation and written estimate(s) of the amount of requested grant to the address below.

The Kelly Packowski MS Foundation
Post Office Box 384
Needham Heights, MA 02494

The Advisory Board will review applications periodically and notify the applicant soon thereafter by mail of the Advisory Board's decision. All information provided by the applicant is confidential and will not be shared with anyone outside the Advisory Board without your written permission. *Please note completion and submission of an application does not guarantee your request will be approved.*

The Advisory Board will not act on incomplete applications and will contact applicant by mail to request the missing information. If information is not received within 60 days, application will be deemed declined and applicant will be sent a notification letter.

If the Advisory Board approves your application, the Foundation will contact you within two weeks by phone to coordinate the payment of the expenses related to the request or to assist in securing and delivering the approved item(s). If the applicant does not respond or provide the necessary information within 60 days of written notification, approval of grant will be revoked.



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If an application is declined, applicant may re-apply for a grant one year from the date of the notification letter.

GRANT APPLICATION CHECKLIST

The following information must be provided for us to review your application.

✓ **Grant Application**

- General Information
- Current Neurologist / Primary Physician
- Applicant Request
- Financial Information
- Medical Insurance

✓ **Neurologist / Physicians Letter**

✓ **Copies of written vendor estimates**

Reminder: we are unable to process requests for reimbursement of any medications, treatments (i.e. acupuncture, massages, etc.), physical therapy, security deposits or items that have already been purchased.

✓ **Signature**

✓ **All information should be sent to:**

The Kelly Packowski MS Foundation
Post Office Box 384
Needham Heights, MA 02494

Once your package is received it will be considered at the next scheduled grant review and you will be notified of our decision by mail shortly thereafter. ***Please note completion and submission of an application does not guarantee your request will be approved.*** All information provided by applicant is confidential and will not be shared with anyone outside the Advisory Board without your written permission.

The Advisory Board will not act on incomplete applications. If the Advisory Board does not think that the application is complete, the Foundation will contact you by letter to request missing information. If you do not respond within 60 days, the application will be deemed declined and you will be sent a notification letter.

If you have any questions on the application process, please contact us at 866-KPMSFND or via the web at <http://www.kpmsfoundation.org/contactus.html>.



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GRANT APPLICATION

General Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Can we leave a message on your voice mail or with another member of your household? Yes No

Gender: _____ Date of Birth: _____ Year of Diagnosis: _____

Current Neurologist / Primary Physician

Doctors Name: _____

Hospital Affiliation and/or Practice Name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Doctor's note stating your diagnosis must be included with your application.

Applicant Request

Please outline what you are requesting (see guidelines above).

Total cost of request. Written estimates must be included with your application.

Other resources for funding. Please indicate how much you are able to contribute towards the purchase. Additionally, please identify any other sources of funding you may have, i.e. family, local chapter of NMSS, community programs, insurance, etc. and the amount they are able to provide.

Please tell us why you require financial assistance at this time.



**The Kelly Packowski
MS Foundation**
Changing One Life at a Time™

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GRANT APPLICATION

Financial Information

Current Monthly Household Income: _____

Total Number of People Living in Household: _____

Number of Adults: _____ Number of Dependent Children: _____

Adjusted Gross Household Income _____
This may be found on your Form 1040, 1040EZ or 1040A

Income Sources

Employment - Self: \$ _____

Employment – Other Members of Household \$ _____

VA Benefits \$ _____

Private Disability Insurance \$ _____

Other, i.e. alimony, family support \$ _____

Additional assets, cash, checking, savings \$ _____

Expenses

Rent / Mortgage, Real Estate Taxes, etc. \$ _____

Utilities \$ _____

Car, Insurance, etc. \$ _____

Medical \$ _____

Other (please specify) \$ _____

Medical Insurance

Please check those that apply: Medicare Medicaid VA None

Private Insurance – Company: _____

Will insurance cover any part of your request: _____

I certify that the information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____

The Kelly Packowski MS Foundation may contact you should we require additional information to consider your application.