steps for Stroke

www.stepsforstroke.org

OVERVIEW

Steps for Stroke, Incorporated ("SFS") is a 501(c)(3) charitable organization which provides qualified Eligible Persons financial assistance for **uninsured** medical expenses. Grants may only be used for medical expenses and transportation to medical appointments for Stroke and Traumatic Brain Injury (TBI) patients. Our goal is to help provide short-term assistance with these expenses that may arise due to a Stroke or Traumatic Brain Injury.

ELIGIBILITY

Eligibility is limited to an individual that has endured a Stroke or Traumatic Brain Injury who currently reside in Warren, Washington or Saratoga County. Final determination of eligibility is at the sole discretion of the Board of Directors of SFS. Only one application per calendar year.

APPLICATION PROCESS

1. Applicant (or sponsor) completes this application.
2. Send completed application and documentation to:

BY MAIL:
Steps for Stroke, Inc.
P.O. Box 3424
Glens Falls, NY 12801

BY E-MAIL: stepsforstroke@gmail.com

3. Maintain a copy of your application and documentation for your records.
4. Allow 2 – 4 weeks for SFS to complete the review of your application.
5. The applicant will be notified of the approval or denial of the application.

PLEASE NOTE

The information provided by each person will be fully considered confidential. Incomplete applications may be returned. We reserve the right to request additional information to make a final decision. The amount of the grant shall be determined at the sole discretion of SFS Board of Directors. The satisfaction of minimum eligibility standards does not guarantee grant approval for financial assistance. SFS does not discriminate based on race, religion, color, national origin, sex, sexual orientation, or political affiliation.

QUESTIONS? If you have any questions, please call: Michelle at 518-744-0649 or Casey at 518-926-8168, or you can e-mail stepsforstroke@gmail.com

INFORMATION ON ELIGIBLE PERSON

Date of Application: _____Name:_____
Address:_____
City: _____State_____
Zip: _____ County:_____Phone:_____
Cell: _____ DOB:_____Email:_____

List names, relationship and ages of all people living in the household:

Name	*Relationship*	*Age*

Reason for Application
In order to aid SFS in providing you with financial assistance that will best address your particular circumstances, please describe how your illness or injury has impacted your ability of day-to-day living.

_____
_____
_____

Describe the current status of health care coverage including Medicare, Medicaid, etc.:
_____
_____

Assistance Requested
Please indicate what type and the amount of assistance you are applying for *(include copies of relevant bills, if possible)*:

☐ Medical Aid (fundable expenses include: doctors, hospitals, medication, specialty medical treatments, rehabilitation/physical, occupational and speech therapy, medical/therapy equipment)
Amount requested $_____
☐ Transportation Amount requested $_____
(Please supply supporting documentation such as a doctor's letter or medical bill indicating diagnosis)

Signature_____Date_____