



OVERVIEW

Steps for Stroke, Incorporated (“SFS”) is a 501(c)(3) charitable organization which provides qualified Eligible Persons financial assistance for **uninsured** expenses.

ELIGIBILITY

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

APPLICATION PROCESS

1. Applicant (or sponsor) completes this application.
2. Send completed application and **documentation (medical bills, etc)** to:

BY MAIL:

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

BY E-MAIL: stepsforstroke@gmail.com or Text: (518) 744-0649

3. Maintain a copy of your application and documentation for your records.
4. **You will receive a follow up phone call so that we can gather additional information on what makes your situation unique and help determine how we can best help you.**
4. Allow 2 – 4 weeks for SFS to complete the review of your information and application. **For faster processing, provide all supporting documents along with the application form.**

PLEASE NOTE

The information provided by each person will be considered confidential to the fullest extent possible. 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? Call: 518-744-0649 or e-mail stepsforstroke@gmail.com

Date of Application: _____

Date of stroke: _____

Name of Eligible Person: _____

Address:

City: _____ State _____

Zip Code: _____ County: _____ DOB _____

Cell: _____ Home Phone: _____

Email: _____

Are you currently employed: (Y/N) _____

Assistance Requested

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

Medical Bills and Expenses (fundable expenses include doctor and hospital copays, medication, rehabilitation/physical, occupational and speech therapy expenses)

Please provide details of need so that we can best help you:

Medical Equipment (items not covered by insurance such as braces, shower seats, grab bars, and other adaptive equipment to help you remain as independent as possible)

Please provide details of need so that we can best help you:

Transportation Assistance (gas money, cab fare, etc)

Please provide details of need so that we can best help you:

Food/Grocery assistance

Other

- If you have additional needs such as paying rent, car loans, etc. we can refer you to other foundations. Steps for Stroke is generally not set up to pay these types of ongoing monthly bills.

I understand that the information provided will be used to determine financial support eligibility from Steps for Stroke. All information will be kept confidential. I understand that the documents I send to prove my eligibility may not be returned. I further understand that the information that I am submitting to Steps for Stroke is subject to verification by Steps for Stroke. I understand if any information provided is determined to be false or incomplete, it can result in disqualification for assistance. All client information is kept confidential and allows Steps for Stroke to collect and maintain accurate data for statistical and accountability purposes.

My signature authorizes Steps for Stroke to verify all information on this form. I certify that the above information is true and accurate to the best of my knowledge. I also have read and carefully understand both the disclaimer and purpose of Steps for Stroke, maintaining my information in a confidential manner.

Applicant Signature _____ Date _____

Print Name and Signature of person filling out the application on behalf of the applicant:

Name: _____

Relationship to the applicant: _____

Contact Number _____