CEREBRAL PALSY ASSOCIATION OF MANITOBA
903-213 Notre Dame., Wpg. MB. R3B 1N3 - 982-4842 or 1-800-416-6166

GRANT APPLICATION FORM

These questions *must* be answered either by using this form or in a letter.

DATE OF APPLICATION -

1. **NAME, ADDRESS AND PHONE NUMBER OF APPLICANT AND/OR CONTACT PERSON: (please print)**

2. **DATE OF BIRTH OF INDIVIDUAL WITH CEREBRAL PALSY?**

3. **HAS THE APPLICANT/FAMILY BEEN A GRANT RECIPIENT IN THE PAST?**

4. **IS THE APPLICANT/FAMILY A CURRENT MEMBER OF THE CEREBRAL PALSY ASSOCIATION? HOW MANY YEARS?**

5. **IS THE APPLICANT/FAMILY APPLYING ON HIS/HER/THEIR OWN BEHALF? IF NOT PLEASE STATE WHO IS?**

6. **WHAT IS THE REQUEST? STATE BELOW & *ATTACH DETAILS* OF THE EQUIPMENT/ITEM(S) WITH *SPECIFIC COST(S) INCLUDING GST & PST IF APPLICABLE*.**

7. **HOW WILL THIS REQUEST ASSIST THE INDIVIDUAL/FAMILY IN AREAS OF PERSONAL, EDUCATIONAL AND/OR SOCIAL DEVELOPMENT LEADING TO A MORE INDEPENDENT AND QUALITY LIFESTYLE? THIS CAN BE ADDRESSED IN YOUR COVER LETTER.**

8. **A. PLEASE NAME ALL OTHER FUNDING SOURCES THAT YOU HAVE CONTACTED.**

   B. WHAT IS THE RESPONSE FROM THESE FUNDING SOURCES REGARDING YOUR REQUEST(S)? PLEASE BE SPECIFIC.

   C. HOW WILL YOU OBTAIN THE ADDITIONAL COSTS NOT COVERED BY CPAM OR OTHER FUNDERS?

OFFICE USE ONLY - DATE APPROVED BY BOARD OF DIRECTORS BY A MOTION:
_____

DATE OF FOLLOW UP: _____

NOTES: ----------