Brain Injury Network of Northern Michigan
GRANT APPLICATION FORM

Please submit application by email to treasurer@braininjurynorth.com.

Required fields are indicated by an asterisk (*).

Eligibility: Candidates must meet these criteria to be eligible. Please initial.
____* I confirm that no other funds are available to the applicant and all other funding options have been explored.
____* The applicant lives in Northern Michigan (North of Clare).
____* A letter of medical necessity and other appropriate support documentation (i.e. prescription from physician) for the item being requested is submitted with this application. Letter of Medical Necessity must include related diagnoses. The letter of medical necessity must demonstrate how this specific device is the most appropriate when compared to others available on the market.
_____* If an Auto Insurer, please provide the following: 1. Denial for payment 2. Reconsideration 3. DIFS complaint 4. DIFS ruling.
_______* Total amount requested.

***Name of beneficiary and contact information:**
First name*-- Middle name(s) -- Last name*:

____

*Address: ____

Address: ____

*City: _________________________________*State: _____ *ZIP: __________

***Primary telephone:** (________) ______________________

Secondary telephone: (________) ______________________ **Extension:** ______

E-mail: ____

***Name of professional submitting application:**
First name*-- Last name*:
____

*Address: ____

Address: ____

*City: _________________________________*State: _____ *ZIP: __________

***Primary telephone:** (________) ______________________

Secondary telephone: (________) ______________________ **Extension:** ______

E-mail: ____

***Has the beneficiary received a BINNM grant in the past year?**
___Yes (Date: _________) or ___ No.
*Applicants may only be approved once within a year following their most recent approval.

***How will the beneficiary contribute 10% of the cost of this device/service/modification?**
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*** Provide documentation of at least 1 attempt to an additional funding source.**

* **Is the beneficiary currently employed?**

*Employer: ____

*City: ______________________ *State: _____ *ZIP: __________

Phone number: (________) ______________________

*Monthly income?: __________ *Monthly expenses?:_______________

What does the scholarship committee need to know about your request in 1,000 words or less? The committee members will be especially interested in these points: beneficiary's goals, disability, what other funding sources have been explored, and what the beneficiary will be able to do with the scholarship funds. Please attach this information to this application. all applications are subject to board approval.

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***The board reserves the right to request additional information and/or the right to offer additional suggestions for funding.**

***The board has up to 1 month to provide a response to the applicant.**

***Certification Statement:**

By signing my name below, I confirm that all of the information provided above and in the accompanying documents is true and correct to the best of my knowledge. This application does not guarantee that I will receive financial assistance and is subject to board approval.

Signed:___________________________________Date:_______________