Grant Application

Margaret Rose Kennedy Foundation
600 Franklin Avenue, #443
Garden City, NY 11530

Only complete applications will be reviewed. This application must be submitted under a cover letter from the referring MSW/CSW, not the grantee.

1) **Grantee Information:**
   Name:
   Street Address:
   City, State. Zip:
   Daytime Phone Number:
   Evening Phone Number:

2) MSW/CSW Referral: Please describe the situation surrounding the individual and state the approximate total funding requested. See page 2 for the financial guidelines. If the grant recipient is a minor child, please provide details of the financial need or hardship of the child's parent(s). Please state income and description of current employment and attach a copy of page one of last year's federal tax return.

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I recommend the above applicant be considered for a grant from the Margaret Rose Kennedy Foundation. This candidate has demonstrated financial need for cancer related medical care not funded by medical insurance.

Signed: _____ Date: _____

Printed Name: _____ Phone: _____

Title & License#: _____ Fax: _____

Address: _____ e-mail: _____

City, State, Zip: _____

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3) Physician Verification: The applicant is under my care for a cancer related medical condition.

Comments: _____

_____

_____

Signed: _____ Date: _____
Printed Name: _____ Phone: _____
Title: _____ Fax: _____
Address: _____ e-mail: _____
City, State, Zip: _____

4) Agreement and Understanding: I understand the determination of the Board will be given to the referring MSW/CSW (section 3) and not directly to the grantee. All decisions are final and additional requests will not be accepted. I agree that, if approved by the Board, any payments from the MRK Foundation will be made directly to the grantee's medical providers for expenses not covered by medical insurance. I also understand the information submitted with this application will form the basis for determining grant eligibility. Any negative tax, legal, or other implications resulting from the possible submittal of false information shall be the responsibility of the undersigned.

Signed: _____ Date: _____
Printed Name: _____ Phone: _____
Relationship to Grantee: _____ Fax: _____
(If Grantee, enter self)
Address: _____ e-mail: _____
City, State, Zip: _____

Financial Guideline: (Source: Federal Dept. of Health & Human Services.

Family Size	Poverty Guideline	MRKF 250%
2	$16,020	$40,050
3	$20,160	$50,400
4	$24,300	$60,750
5	$28,440	$35,550
6	$32,580	$81,450
7	$36,730	$91,824
8	$40,890	$102,224