KRide Inc. Grant Guidelines

The following Guidelines are intended to communicate our organization's mission, priorities and application procedures.

MISSION

The corporation is created and shall be operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, amended, either directly or by making contributions to individuals and organizations duly authorized and permitted by law to carry on such activities. The Primary purpose of this corporation shall be to raise funds to be distributed to such charitable organizations and persons engaged in the research, treatment, cure of, and education about, cancer or other diseases.

PRIORITIES

The primary focus of KRide, Inc.'s charitable giving program is to provide assistance and support to children and their families in Western Massachusetts who are fighting cancer. A single grant in the amount of $1,000.00 is awarded per calendar year to assist individuals and families with financial hardship as it relates to their medical needs.

Larger amounts may be granted, if considered appropriate by the Directors.

Grant requests are submitted in written form using KRide, Inc.'s grant application. Applications for the grant program are accepted throughout the year. If grant is approved, the person requesting aid and the candidate will be informed. The application is available upon request or online through the organization's website.

If no applications are received in a given year, a grant may be awarded at the discretion of the Directors to a family in Western Massachusetts who is fighting cancer.

ELIGIBILITY

To be considered for grant funding, requesting families must:

- Reside in Western Massachusetts
- Not have received financial assistance from KRide Inc. within last 5 years

Examples of appropriate grant requests include requests:

- to cover unexpected medical expenses
- to contribute towards medical insurance expenses
- to cover the cost of transportation to treatment
- to cover the cost of hotel stays while receiving treatment

APPLICATIONS

Requests for assistance may come from individuals, family members, treatment center staff, case managers, and other agencies on behalf of an individual or family seeking grant funds.

All applicants must fully complete the application form.

- Every portion of the application form must be filled out. Do not leave any lines or spaces blank. Indicate "n/a" if something is not applicable.
- Grants will be awarded October 1.

Completed applications may be submitted to:

KRide, Inc.
PO Box 755
Springfield, MA 01101-0755

GRANT APPLICATION FORM **Date**_____

Candidate

First Name: _____ Last Name: _____ Middle Initial:_____

Date of Birth: ____/ ____/ ____ Gender: □ Female □ Male
The candidate must be <18 years

Address: _____ City: _____ State: ____ Zip: _____

School: _____ Grade: _____

Year Diagnosed: _____

Type of Cancer: _____

Location where treatment is received: _____

Oncologist's Name: _____ Oncologist's Phone _____

Primary Doctor's Name: _____ Primary Doctor's Phone: _____

Applicant

First Name: _____ Last Name: _____ Middle Initial:_____

Date of Birth: ____/ ____/ ____ Gender: □ Female □ Male
The applicant must be 18 years or older

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Email address: _____

What is your relation to the candidate? _____

If a guardian of the candidate, may KRide, Inc. have permission to share your story and/or a picture if awarded the grant? □ Yes □ No

How did you hear about KRide, Inc.? _____

_____

Would you be interested in learning more about the upcoming Katelynn's Ride? □ Yes □ No

General Application

Please provide a statement indicating the applicant's need or the applicant's family's need for this requested grant.*

_____
_____
_____

_____
_____
_____
_____
_____
_____
_____

Please provide a statement indicating why you believe the candidate is deserving of the requested aid.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

To your knowledge, has an application been completed for the candidate in the past? □ Yes □ No

Has the applicant ever received financial assistance from another organization?* □ Yes □ No

If yes, name of organization: _____ Amount: $ _____

Purpose of financial assistance: _____

**If necessary, use additional paper*

I confirm that the information provided on this application form and in all supplemental documentation is complete and accurate. I give consent, and hereby authorize, KRide, Inc. to verify the information contained in this application and in all supplemental documentation. KRide, Inc. may contact any company, agency, medical office, referral source, case manager, treatment center, doctor, nurse, or service provider to obtain any further necessary information in the course of grant review and, if approved, grant disbursement.

The information that has been disclosed to KRide, Inc. may be protected by state and/or federal laws that protect confidentiality. Any and all information pertaining to grant applicant and candidate is strictly confidential and proprietary to the Foundation consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I release any of the involved companies, agencies, institutions, persons, etc., KRide, Inc. staff and Directors and counsel from all legal responsibility or liability that may arise from authorized release of this information. I understand and that I may revoke this consent at any time. This consent expires two years after the date signed.

By signing, I attest that I have read the above and agree to abide by the policies of the Individual Grant program as outlined in this application and through all other correspondence with the KRide, Inc.

Signature: _____ Date: _____

Print Name: _____