



# We Rage, We Weep Alzheimer Foundation

## GRANT APPLICATION PROCESS

### *Our Mission*

To ensure that no caregiver feels alone, isolated or without financial resources.

#### **FIELD OF INTEREST**

The Foundation's interests in the field of Alzheimer's care are comprehensive and extend to health care, mental health, physical care, accident prevention and nutrition.

#### **AREA SERVED**

The Foundation supports the proven needs of persons affected by Alzheimer disease or related dementias in the Capital Regional District.

#### **GRANT PROGRAM**

Purposes of the Foundation are served through grant support to individuals awarded in response to requests that fit the requirements as approved by the board. Grants are awarded to support and improve the quality of life of the affected persons and to facilitate the tasks of the caregivers.

#### **PROGRAM PRIORITIES**

In considering proposals, priority is given to funding assistance which serves the Foundation's priority interests. The Foundation seeks to support programs which

- provide information and community education to improve the health and well-being of persons affected by Alzheimer disease and related dementias
- foster individual responsibility, independence and self-care
- strengthen families as the critical unit for health and well-being;
- expand access to quality care and services for people with financial need.

#### **ELIGIBILITY**

The Foundation will not replace statutory or other funding available to support basic services. Grants are made to support the cost of services and supplies.

Applications are funded based on established need and by the availability of funds.

#### **WHEN TO APPLY**

Applications will be accepted and considered on an on-going basis.

#### **HOW TO APPLY**

Grant applications should be submitted as written proposals to the Foundation and mailed to **We Rage, We Weep Alzheimer Foundation** at the address below.

Please present information on your proposal in the format outlined below. Use this outline as a checklist. Incomplete applications will not be considered, but returned to you for additional information. As a rule, applications should be stapled (not bound) sheets with page numbers.

- Briefly describe your situation, the current status of the person(s) affected with the disease and services currently being provided.

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For questions regarding the application process or your proposal content and strategy, please contact \_\_\_\_\_ at \_\_\_\_\_. We encourage you to call before completing your application.

**Attachments**

With all proposals, please include:

- completed Project Budget Sheet, with explanatory comments
- latest income tax return
- up to 3 letters of support
- last 3 months bank statements

Applications should be sent to:

**We Rage, We Weep Alzheimer Foundation**

# FUNDING APPLICATION GUIDELINES

## ELIGIBILITY REQUIREMENTS

**To apply, you must meet the following Eligibility Requirements:**

The person affected must be diagnosed by a practicing, certified physician as suffering from "Alzheimer's disease," "probable Alzheimer's disease," "dementia of the Alzheimer's type" or related dementias. **The physician's statement must have one of the above diagnoses for the patient to be eligible. Original documentation with the physician's actual signature must be submitted; no photocopies or stamped signatures by the physician will be accepted.**

## INSTRUCTIONS

**Please complete the entire application. All information on the application will be taken into consideration in determining the urgency of need. Failure to complete all sections of the application will result in a delay in reviewing the application.**

- ❖ The physician's diagnosis should be included with this application and should be written on the physician's stationery or prescription pad. Original documentation with the physician's actual signature must be submitted; no photocopies or stamped signatures by the physician will be accepted.
- ❖ All applicants whether denied or approved, will receive notification in writing. If denied, the letter will include an explanation of denial. A copy of the letter will also be sent to the caregiver (if not the spouse) listed in the application.
- ❖ This application may be reproduced and/or faxed as needed. However, if an application is faxed, please also mail **this application** with original signatures. The faxed copy will be reviewed for approval; however, the application will not be funded until original signatures are received. This application may also be downloaded from the website at: [www.weragewewweep.com](http://www.weragewewweep.com)

## RELEASE OF INFORMATION

In an effort to inform the public about the crises faced by Alzheimer's patients and their caregivers **We Rage, We Weep Alzheimer Foundation** uses case information from the persons affected and caregivers who have received help. This information generates the support that enables the Foundation to provide assistance to individuals like yourself. It would be helpful to us if you would sign the Release of Information below. Be assured that this is not a prerequisite to obtain assistance from the Foundation. If your case information is used only the facts about your situation will be included. We will not use your full name, exact location or financial information.

"I consent to the use of my case information to make others aware that financial assistance is available through the **We Rage, We Weep Alzheimer Foundation.**"

Name of person affected: \_\_\_\_\_ Date: \_\_\_\_\_

Caregiver/Spouse/Family member's name (print): \_\_\_\_\_

Caregiver/Spouse/Family member's signature: \_\_\_\_\_

**Please print or type all information.**

**INFORMATION ABOUT THE PERSON AFFECTED**

Name of person affected: \_\_\_\_\_ Gender: M F  
Date of Birth: \_\_\_\_\_ Social Insurance Number **(Required)**: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**INFORMATION ABOUT THE CAREGIVER**

Caregiver/Spouse/Family Member's Name: \_\_\_\_\_ Gender: M F  
Date of Birth: \_\_\_\_\_ Social Insurance Number **(Required)**: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
What is your relationship to the patient? \_\_\_\_\_  
Is the patient your dependent? Y / N  
Do you have any other dependents? Y / N **(if yes, how many and ages)**: \_\_\_\_\_  
Have you applied for other assistance prior to this for yourself or the person affected? Y / N **(if yes, give date)**: \_\_\_\_\_

I declare that to the best of my knowledge, this statement of assets, liabilities and other information is truthful, complete and accurate.

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the person affected is unable to sign, signature of individual authorized to sign on his/her behalf:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name (please print):** \_\_\_\_\_

Type of signature authority **(durable power of attorney, guardian, etc.)**: \_\_\_\_\_

**Please attach copies of all legal paperwork/documentation.**  
**Please attach copies of power of attorney, guardian, etc.**



## PERSON AFFECTED & SPOUSE FINANCIAL INFORMATION

**NOTE: THIS INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL**

**Please provide complete information for both the person affected and spouse.**

**Make sure all spaces are completed with an amount or "0".**

### ASSETS

#### LIQUID ASSETS

Chequing Acct \$ \_\_\_\_\_  
 Savings Acct \$ \_\_\_\_\_  
 Stocks & Bonds \$ \_\_\_\_\_  
 Other liquid assets \$ \_\_\_\_\_

#### FIXED ASSETS

Home (*assessed value*)  
 \$ \_\_\_\_\_  
 Auto (*assessed value*)  
 \$ \_\_\_\_\_  
 Year: \_\_\_\_\_  
 Make/Model: \_\_\_\_\_  
 Other assets \$ \_\_\_\_\_

**TOTAL ASSETS \$ \_\_\_\_\_**

### LIABILITIES

Mortgage (*amount remaining*)  
 \$ \_\_\_\_\_  
 Auto loan (*amount remaining*)  
 \$ \_\_\_\_\_  
 Other liabilities (*specify*)  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL LIABILITIES \$ \_\_\_\_\_**

### MONTHLY INCOME

Monthly pay (*if employed*)  
 \$ \_\_\_\_\_  
 Retirement income \$ \_\_\_\_\_  
 CPP/OAP \$ \_\_\_\_\_  
 Veteran's benefits/Widow benefits  
 \$ \_\_\_\_\_  
 Dependent's benefits:  
 Child support \$ \_\_\_\_\_  
 EI \$ \_\_\_\_\_  
 Alimony \$ \_\_\_\_\_  
 Other income  
 (*source \_\_\_\_\_*) \$ \_\_\_\_\_

**TOTAL MONTHLY INCOME \$ \_\_\_\_\_**

### MONTHLY HOUSEHOLD EXPENSES

Rent  Mortgage \$ \_\_\_\_\_  
 (*Check one*)  
 Food \$ \_\_\_\_\_  
 Utilities \$ \_\_\_\_\_  
 Transportation \$ \_\_\_\_\_  
 Auto payment \$ \_\_\_\_\_  
 Other expenses (*specify*)  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

### MONTHLY INSURANCE EXPENSES

Medical/Dental \$ \_\_\_\_\_  
 Life \$ \_\_\_\_\_  
 Renter/Homeowner \$ \_\_\_\_\_  
 Auto \$ \_\_\_\_\_

### MONTHLY MEDICAL EXPENSES

Nursing care \$ \_\_\_\_\_  
 Respite care \$ \_\_\_\_\_  
 Adult day care \$ \_\_\_\_\_  
 Doctor bills \$ \_\_\_\_\_  
 Hospital bills \$ \_\_\_\_\_  
 Medications \$ \_\_\_\_\_  
 Personal hygiene supplies \$ \_\_\_\_\_  
 Other expenses (*specify*)  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL MONTHLY EXPENSES \$ \_\_\_\_\_**