

Grant Application



****THE ENTIRETY OF THIS APPLICATION MUST BE COMPLETED IN ORDER TO BE CONSIDERED FOR APPROVAL OF FUNDS**

Grants Available: January 1st – December 31st; one grant per year
Request Maximum: up to \$250 per year

Date of Application: _____

Applicant Information:

Name of Applicant: _____

Street Address: _____

City/State/Zip: _____

Phone #: _____ Email: _____

Application Questions:

Do you have Parkinson's or Parkinsonism? _____ Yes _____ No

Do you care for someone living with Parkinson's or Parkinsonism? _____ Yes _____ No

Grant request (please provide brief description): _____

What benefit will this provide? _____

Have you applied for financial assistance for the requested item from another source? _____ Yes _____ No
(i.e. Independent Living Choices, Dakota at Home, Medicare/Medicaid/Insurance)

If yes, please list: _____

Amount Requested: _____

In support of the mission, SDPF hopes to provide financial assistance for specific items, services, and programs that will aid in helping individuals, families, and support groups across the state of South Dakota. If you feel this applies to you, please fill out the entire application and submit to:

SD Parkinson Foundation
5024 S. Bur Oak Place, Ste 217
Sioux Falls, SD 57108
info@sdparkinson.org

SDPF does not provide financial assistance for any type of medical expenses including but not limited to medical bills, medications, medical trials, and any type of doctor/specialty visits. SDPF also does not provide gift cards for any requested amount.

For Office Use Only:

Office Follow-up by: _____ ***Date:*** _____ ***Okay to Pay:*** _____

Paid by: _____ ***Date:*** _____