Make Lemon Aide® Foundation for CP

First Step Recovery Model Grant Application

The Make Lemon Aide® Foundation for Cerebral Palsy ("CP") is a 501(c)(3) non-profit foundation that was established in 2013 in effort to bring awareness to CP.

Grants offered Bi-Yearly

Cycle 1- April - September
Applications due before February 28th
Notified in March

Cycle 2- October - March
Applications due before August 31st
Notified in September

Any person of any age with a registered physician's active diagnosis of cerebral palsy, including pediatric patients (under 18 years of age) and their parents, guardians or legal custodians, who are U.S. citizens.

"Applicants may apply for a Make Lemon Aide® Foundation for CP - First Step PT First Step Recovery Model ("FSRM") Physical Therapy Grant ("Grant") regardless of race, color, sex or national origin. The Application must be completed by patients 21 years of age and older and their parents, guardian or legal custodians.

First Step Recovery Model physical therapy, (www.firststeppt.com) is a highly effective treatment model for achieving maximum results consisting of 10 components and 7 steps. All First Step Physical Therapy therapeutic doctors and physical therapist(s) must be trained in these 7 steps and 9 components and utilized at all times when it comes to providing treatment for grant recipients.

Grant Application Process

- Applicants must submit an application by the deadline as described previously and the Application must be received by the Make Lemon Aide® Foundation for CP.
- Make Lemon Aide® Foundation for CP in its sole discretion will review the applications, taking into account many factors of applicants for evaluation and may elect to approve the application or elect to not approve the application. Make Lemon Aide will notify Applicants accordingly by phone or email.
- Each grant awarded will be specific to the applicant based on other insurance coverage, medical care plans and other factors taken into account by the grant committee.
- Grants are awarded only on a bi-yearly basis for a 6 month period starting in April or October.
- Only one (1) grant will be awarded per applicant per cycle.
- If the Grant hours are not fully used by the end of the grant cycle for the first and second grant cycles respectively, the remaining grant hours awarded are null and void without any exception or circumstances.
- First Step Physical Therapy will be awarded for the sole purpose of addressing an applicant's physical therapy needs – including an initial evaluation at one of their locations.
- Travel and lodging are the responsibility of the grant recipient, as such expenses are not included in a grant.
- This application does not guarantee that a grant will be awarded. If not awarded it does not mean that the Application lacks merit. However, by applying for a Grant the Applicant understands and agrees with the terms and conditions of this Application and acknowledges that the Make Lemon Aide® Foundation for CP, is incorporated as Make Lemon Aide®, Inc., a State of Georgia, U.S.A. corporation and a private, 501(c)(3) organization with limited resources.
- ***We respectfully request no phone calls or emails inquiring about the status of your application. All applicants will be notified of determination as soon as possible.***

Other Grants Requirements

1. Applicants must use good faith to first utilize insurance coverage or any other assistance awarded. Once depleted or if this does not pertain to the applicant then the applicant can apply for a Make Lemon Aide® Foundation for CP - FSRM Physical Therapy grant.
2. Once insurance reimburses applicants, the applicants are required to bring in all checks that they receive from their insurance company as reimbursement for their treatment at First Step Physical Therapy. This includes any and all correspondence that is attached to the check, such as an explanation of benefit (EOB).
3. If an applicant qualifies for Medicaid or Medicare or any other assistance, they must utilize these hours with First Step PT only in order to qualify for a grant from Make Lemon Aide® Foundation for CP.
4. Applicants are **required** to support the Make Lemon Aide® Foundation for CP through community fundraising.

Section 1: Applicant Basics

Applicant Information:

Name of Applicant:_____

Primary Contact:_____
(If not self)

Relationship to Applicant:_____

Applicant Date of Birth:_____

Diagnosis:_____
****Documentation required for diagnosis specified in section 2****

Contact Information:

Street Address: _____

City:_____ State: _____ Zip Code: _____

Phone:_____

Email Address:_____

Insurance Information:

Have you received funding from any other organization(s) this calendar year? ☐Yes ☐No

If so, list organization(s)_____

Do you have health insurance? ☐Yes ☐No

Primary Insurance	Secondary Insurance (if applicable)	Tertiary Insurance (if applicable)
Company:	Company:	Company:
ID Number:	ID Number:	ID Number:
Policy Holder:	Policy Holder:	Policy Holder:

Section 2: Supporting Documents

1. Official Medical Documentation Confirming CP Diagnosis
    - This may include a doctor's note, prescription for treatment, medical record, or any other document that confirms the applicant's medical condition
2. Personal Statement on Daily Life
    - This is an opportunity to help us understand the challenges you face as an individual with CP and how this grant could make a difference in your life. Share what your day-to-day life is like and anything else you feel is important for us to know.
    - Tell us how willing you are to attend therapy and work toward your treatment goals. Physical therapy can require both time and effort, and this information helps us ensure the grant is supporting someone who is ready and able to actively participate in their care. Please share how you prioritize therapy in your life and how this grant could support your commitment.
3. Photo of the Applicant
    - Please include a recent photo of yourself. This helps us connect with you as a person beyond your application and diagnosis. This is optional, but we encourage it to help us better understand your story and who you are as an individual.

Application can be submitted by email, or delivered in-person

➢ **Email Address** (as PDF attachments) **IMPORTANT: Please email to both Carol Walier & Sherry Walier and cc First Step PT to ensure everyone receives the application**.
cwalier@hotmail.com & sherrywalier@comcast.net
You must cc: adminbuffalo@firststepphysicaltherapy.com

➢ **In Person Drop-Off**

First Step Physical Therapy
2564 Walden Ave Suite 105
Cheektowaga, NY 14225

Section 3: Signatures

HIPAA AUTHORIZATION

Leger Therapy Services, Inc. DBA First Step Physical Therapy is authorized to disclose the following protected health information to my Grant Provider, Make Lemon-Aide for Cerebral Palsy.

The health information that may be disclosed is:

- Medical records
- All treatment records
- Other: insurance benefits, when insurance sends reimbursement checks, quantity of past and future appointments, account balance, previous payment history, therapist recommendation for quantity of visits needed

All past, present, and future periods of healthcare information may be shared.

The purpose of this use or disclosure is so that Make Lemon-Aide can pay account balance and assess visits needed for future grants.

This Authorization Form is valid beginning upon submission of this application and expires at the end of the cycle applied for.

I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Name: _____

Parent or Guardian: _____

Signature : _____ Date: _____

MEDIA AND PROMOTIONAL RIGHTS

If an award is granted Applicant hereby grants, for himself/herself and on behalf of Applicant(s) under the age of 18, permission to use the Applicant's name and likeness, including photos and other biographical information, in order to promote the charitable purpose of the Make Lemon Aide® Foundation for Cerebral Palsy and Make Lemon Aide®, Inc. in connection with the Application and Grants for Make Lemon Aide® Foundation for Cerebral Palsy FSRM Physical Therapy Grant provided to First Step PT.

Patient Name: _____

Parent or Guardian: _____

Signature : _____ Date: _____

RELEASE AND WAIVER OF LIABILITY

I understand that the above are requirements. If the application is not completed in full or missing supporting documents the application will not be reviewed.

In consideration for receipt and review of this Application for a Make Lemon Aide® Foundation for Cerebral Palsy, the FSRM Physical Therapy Grant provided to First Step PT, Applicant, as identified below does hereby release, discharge and agree to hold harmless, and agrees to indemnify the Make Lemon Aide® Foundation for Cerebral Palsy and Make Lemon Aide, Inc., its directors, officers, employees, agents and assigns against and from any causes of action, claims, demands, damages, costs, expenses, all consequential damages and attorneys' fees (regardless whether pursuant to the laws of any county, state or country) claimed by, through or on behalf of the Applicant(s) and, if applicable, Applicant's parents, guardians, custodians, and their agents, related directly or indirectly to this Application for a Make Lemon Aide® Foundation for Cerebral Palsy FSRM Physical Therapy Grant.

The Applicant(s), as identified below, further expressly agrees that this release is intended to be as broad and inclusive a release of liability as permitted by applicable law and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. The Applicant(s), as identified below, hereby warrant and represent that he/she has carefully read this release and agree to its terms and conditions, that before signing this release he/she had the chance to ask questions; and he/she is aware that by signing this release, he/she assumes all risks and waives and releases certain substantial rights that he/she may have or possess against the Make Lemon Aide® Foundation for Cerebral Palsy and Make Lemon Aide, Inc.

Applicant hereby by agrees for himself/herself and on behalf of Applicant(s) under the age of 18, that any materials or information submitted with the Application to the Make Lemon Aide® Foundation for Cerebral Palsy and Make Lemon Aide, Inc. may be disclosed to and shared with third parties for the purpose of the evaluation of the Application.

Patient Name: _____

Parent or Guardian: _____

Signature : _____ Date: _____

END OF APPLICATION

For internal use only	Date Received _____