Sherri Little Foundation Grant Application

We provide micro-grants of $1,000 or less to chronic pain patients with limited support and resources. These grants may be used for travel to see specialists, medical equipment, alternative therapies, treatments, and other expenses insurance doesn't cover. At this time, The Sherri Little Foundation, Inc. can only provide grants to patients in the United States. We're working to open up to more areas in the future.

"*" indicates required fields

Grant Applicant

Applicant Name *

First

Last

Applicant Email Address *

Enter Email

Confirm Email

Applicant Mailing Address *

Street Address

Address Line 2

City

State

ZIP Code

Applicant Phone *

How Did You Hear About The Foundation?

About You

What are your preferred pronouns? *

- ◯ Female: "Wish her a happy birthday!"
- ◯ Male: "Wish him a happy birthday!"
- ◯ Neutral: "Wish them a happy birthday!"

What Is Your Age? *

- ◯ Under 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65 or Above

What Is Your Annual Household Income? *

Grant recipients must be at or below 200% of the HHS poverty guidelines for the current year, as based off your last year's tax return, which you will upload below.

Number Of People In Your Household *

Grant recipients must be at or below 200% of the HHS poverty guidelines for the current year. This is calculated by both income and number of persons in the family/household.

Last Year's Tax Return

To verify your income eligibility, please upload a copy of your tax return from last year (Form 1040, 1040EZ, or 1040A). Supporting documents or schedules are not required.

Choose File | no file selected

Accepted file types: pdf, jpg, gif, png, Max. file size: 256 MB.

More About You

How Long Have You Been Living With Chronic Pain? *

How Do You Hope To Use This Grant? *

Explain how you plan to use the grant, whether it's for treatment, medical equipment, or other needs.

0 of 750 max characters

Cost Of Treatment, Medical Equipment, or Other Needs *

Please provide an estimate of the costs for the treatment, medical equipment, or other needs you plan

to cover with this grant. Note that a written estimate, invoice, or statement will be required before we can pay the provider or vendor. For medical treatments, a HIPAA release will be required to communicate with your provider.

How Would You Like To Submit Your Story? *

You have the option to either provide written answers or, if more convenient, record a video and share a URL where we can access it.

- ◯ Written answers to questions on this application
- ◯ Record and submit a video via URL (for example, a private YouTube link)

Tell Us About Yourself And Your Pain *

Please provide a description of your chronic pain condition, including how it has developed over time.

0 of 2000 max characters

How Will This Benefit You? *

Explain how you believe the treatment, medical equipment, or other use of the grant will benefit you. Include the likelihood of this improving your pain and quality of life.

0 of 2000 max characters

Grant Guidelines

Letter From Your Provider *

We require a letter of medical support from either the medical provider who diagnosed your chronic pain condition or is responsible for your treatment. This letter should be printed on the medical provider's letterhead and confirm the need for the specific treatment, medical device, or other needs included on this application.

Choose File | no file selected

Accepted file types: pdf, jpg, gif, png, Max. file size: 256 MB.

Directly Paid To Providers *

Grants are paid directly to the provider of the treatment, medical device, or other needs. Applicants will need to sign a HIPAA release to allow for this.

☐ **I agree to provide any necessary HIPAA consent forms.**

Must Be Paid In 12 Months

Grants must be paid out to provider within 12 months of award date. If grant is unused, grant recipient may reapply.

☐ **I agree to use the grant within 12 months.**

Financial Need *

Grants are awarded to individuals who demonstrate financial need and fall at or below 200% of the current year's HHS poverty guidelines as based off applicant's prior year's tax return.

☐ **I understand that grants are awarded based on financial need and will provide my prior year's tax return.**

United States Resident *

Grants are available to US residents only.

- [ ] **I am a resident of the United States.**

Final Interview *

Grant finalists will have an interview with our selection committee. Interviews will be in-person, virtual, telephonic, pre-recorded, or in whatever manner the committee deems appropriate.

- [ ] **I agree to a final interview.**

Signature *

By typing your name below, you are digitally signing this application and verifying that all of the information you have provided is complete and factually correct.