Small Comforts Foundation, LTD. a non-profit organization
One Leslie Lane, Ithaca, New York 14850
607. 279. 0981
ccima@aol.com

Gifts and Assistance Program Application

The Small Comforts Gifts and Assistance Program gives items of personal comfort and various types of assistance to persons on a limited budget whose medical condition or life circumstances create a serious loss of morale or quality of life. It is a gift with no responsibility for repayment by the individual or any other party.

OVERVIEW AND GUIDELINES FOR APPLYING TO THE COMFORT GIFTS AND ASSISTANCE PROGRAM

Small Comforts Foundation, Ltd. (SCF) is a not for profit organization dedicated to funding and administering programs that will raise the morale and improve the quality of life for the chronically or terminally ill. It is our mission to accomplish this through providing the best resources and information possible and establishing programs that will make a difference in the daily lives of people afflicted with chronic illness.

Comfort Gift will be awarded to individuals or families for the purpose of improving the life of a chronically ill person. Examples of previous awards include air conditioners, wheelchairs, recliners, walkers, talking wrist -watches, shower chairs, blood pressure monitors, televisions, stereos, DVD players etc. A Comfort Gift award is at the sole discretion of the board of directors of SCF. Recipients will be chosen on the basis of information provided in their essay.

Assistance Through the Margie Vorhis Family Assistance Program is available for certain types of situations resulting from a person's illness. Each request for assistance is considered on its own merit depending on the family's circumstances and need. Recipients will be chosen on the basis of their essay at the sole discretion of the board of director of SCF.

Requests for cash will not be considered. Comfort Gifts and Assistance are awarded to individuals or families, Organizations, companies, and corporations are not eligible for Comfort Gifts.

The signed Physician's Verification Letter **must** accompany applications. Recipients will be notified by mail after review by the Small Comforts Board of Directors.

Application

Small Comforts

Please fill out the following information: Date: _____

Applicant's Name: _____

Address: _____

_____

_____

Phone Number: _____

Email Address _____

Item or Assistance you are requesting: (Please limit your request to one item or form of assistance)

_____

Annual Income $ _____

Type of Government Assistance you are now receiving _____

_____

Name of Case Worker if applicable _____

Phone No. of Case Worker _____

Have you ever applied to SCF before? Yes _____ No _____ When _____

What item or help did you receive? _____

What form of Chronic Illness are you living with?

_____

Where did you hear about Small Comforts?

_____

In the space below please answer each of the following questions.
You may attach a separate sheet of paper if you have additional information you would like to share with us. It is very important that you answer each question completely so we may understand how your illness is affecting your life.

1. What is your primary health problem that this request will help to improve?

_____

2. List any secondary health problems.

_____

_____

3. How does your primary illness affect your daily life?

_____

_____

4. What effect will receiving this request have on your daily living situation?

_____

_____

_____

5. What is the hardest daily problem that you are living with as a result of your illness? And how will receiving this gift help this problem?

_____

_____

_____

6. What kind of help are you currently getting from family and friends?

_____

_____

7. Do you live alone or with family?

_____

_____

8. Please use the space below to tell us anything else you would like us to know about your situation. Please note the more clearly you state your situation and reason you desire your request the more likely we are going to be able to help. Attach extra sheet if necessary.

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Physician's Verification Letter

Small Comforts

Gifts and Assistance Program

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As the physician of _____

I am aware of my patient's application to the Small Comforts Gifts and Assistance Program and feel that this patient would benefit from their request of

_____

Please tell us why you believe that this gift or assistance will raise the morale and or quality of life for your patient.

_____

_____

Physicians Name Please Print: _____

Physicians Address: _____

_____

Note this form must be signed by Physician not PA or other Staff

Physicians Phone Number: _____

Physician's Signature: _____

Date

_____

Return along with completed application to:
Candy Cima
One Leslie Lane
Ithaca, NY 14850