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| https://3.bp.blogspot.com/-M8KKzn3mYEw/WyQm-mtGL6I/AAAAAAAAARg/HytMcyFUyK0t6FoZaDUp1jBgLK5llNYdgCLcBGAs/s1600/SuperT.jpg | 2021 Grant Application for Super T’s Mast Cell Foundation (STMCF) |

## Introduction and Parameters

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| Super T’s Mast Cell Foundation (STMCF) was started based off a dream and passion fueled by “Super T”, Taylor Nearon. After receiving a medical diagnosis of a rare condition, otherwise known as Mast Cell Disease, Taylor wanted to make a change. She took her passion for helping others to form this foundation to ensure no one had to battle alone.Our vision at STMCF is to improve the quality of life for patients affected by mast cell by offering grants to help offset living and medical expenses. We are committed to uplifting those affected by mast cell disease, while using our passion to make a difference by having an open-minded approach regarding raising awareness for mast cell disorders.For the 2021 grant selection, applications for STMCF funds will be accepted from March 31, 2021 – August 31, 2021, with all recipients being notified by October 1, 2021. Early application is recommended. Super T’s Mast Cell Foundation will not be responsible for lost or misdirected e-mail, mail, or applications that are post marked after the deadline.STMCF and its Grant Selection Committee, Board of Directors, and Officers certify and promise all information/documentation obtained from applicants/patients and letters from physicians will be kept confidential and stored in a secure and safe location and solely viewed by the STMCF Grant Selection Committee, the Board of Directors, and Officers of Super T's Mast Cell Foundation for the purposes of determining grant eligibility and distribution; the information and documentation provided will not be used for any other purpose. Before you begin, please review the grant criteria outlined below and place an “X” before each statement to ensure eligibility.  |
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|  I am the patient and I am 18 years of age or older.  |  |  |  | YES | NO |

 I am a family member or guardian applying on behalf of a patient, with his/her approval. (Please provide documentation supporting this.) |
|  I have an official diagnosis of a Mast Cell Activation Disease, this includes Mastocytosis or Mast Cell Activation Syndrome. (Please provide a letter from your treating physician documenting diagnosis. This letter must be dated on or after January 1, 2018.) I have not been awarded a grant in the past two years. |
|  If selected to become a grant recipient, I will write a brief testimony reflecting the impact of being awarded a grant. |

## Grant Applicant Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

## Please answer the following questions:

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| 1. Have you ever applied to a STMCF grant in the past? If so, when?
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| 2) Are you currently employed? If so, full-time or part-time?  |
| 1. Do you currently have insurance to cover your medical needs?
 |
| 1. Do you live alone? What support system do you have in place?
 |
| 1. Do you require compounded medication as part of your treatment plan? If so, are they covered by insurance?
 |
| 1. How long have you been living with a Mast Cell Activation Disease?
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|   7) Have you been diagnosed with other conditions in addition to a mast cell activation disease? If so, what are they? |
| 1. Are you presently experiencing symptoms? Is your condition controlled?
 |
| 1. Do you require daily Benadryl administered IV/IM, PO, or through feeding tube as your primary medical protocol?
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| 1. Do you currently have either a central line or feeding tube? (Or both?)
 |
|   11) Have you ever required the use of an Epi-Pen? |
| 1. Have you ever been treated in the ER for anaphylaxis? How was your experience?
 |
| 13) Have you been hospitalized within the past year due to a mast cell activation disease? If so, how many times? |
| 14) Do you require the use of a wheelchair or other mobility device? |
| 15) What is your monthly *average* out of pocket medical related expense? (Do not include medical costs covered by insurance.) |
|  16) How would being awarded a grant help you? |

## Grant Submission Instructions

Please scan a copy of this completed grant application, along with any additional supporting documentation as needed, and e-mail to STMCF at tc.trstmcf@gmail.com, or mail to 211 Hearthstone Road, King of Prussia, PA 19406. Applications being mailed must be postmarked no later than August 31, 2021.

All entries will be accepted from March 31, 2021 - August 31, 2021.

## Disclaimer and Signature

I certify that my answers are true, correct, and complete to the best of my knowledge. I further certify that I am voluntarily and of my own desire and free will providing personal medical information and/or documentation regarding my medical condition and diagnosis; or am doing so on behalf of a minor as his/her parent or guardian; or am doing so on behalf of a family member or friend with his/her express consent to do so.

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| --- | --- | --- | --- |
| Signature: |  | Date: |  |