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| https://3.bp.blogspot.com/-M8KKzn3mYEw/WyQm-mtGL6I/AAAAAAAAARg/HytMcyFUyK0t6FoZaDUp1jBgLK5llNYdgCLcBGAs/s1600/SuperT.jpg | 2022 Grant Application for  The TAYLOR NEARON GRANT |

## 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 Activation Disease, Taylor wanted to make a change. She took her passion for helping others to form this foundation ensuring patients always felt supported.  The creation of the Taylor Nearon Grant will be awarded to a recipient who reflects the same values, creativity and commitment to the MCAD community that was exhibited by Taylor during her valiant fight. Helping others no matter her circumstance was the cornerstone of who Taylor was.  For the 2022 grant selection, applications for the Taylor Nearon Grant will be accepted from May 1, 2022 – September 30, 2022, with all recipients being notified by November 15, 2022. Super T’s Mast Cell Foundation will not be responsible for lost or misdirected e-mail, mail, or applications post marked after the deadline.  STMCF and its Grant Selection Committee, Board of Directors, and Officers certify and promise that 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 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. Place an “X” before each statement below to ensure eligibility. |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | I have been diagnosed with a mast cell activation disease less than 5 years. |  |  |  | YES | NO | | I am the patient and 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, 2019.)  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:

1. **What is your hobby? Example, crafting, blogging, journaling, Facebook group, etc.?**

1. **How have you made an impact on the MCAD community?**
2. **How do you balance having a chronic illness with everyday expectations?**
3. **What is your motivation each day?**
4. **Are you part of any groups? Example online MCAD community**

**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](mailto:tc.trstmcf@gmail.com), or mail to 211 Hearthstone Road, King of Prussia, PA 19406. Applications being mailed must be postmarked no later than September 30, 2022.

All entries will be accepted from May 1, 2022 - September 30, 2022.

**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: |  |