**Organization Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant Organization *(checks will be mailed to)*: | | | |
| For-Profit  Non-Profit | | | |
| Mailing Address: | | | |
| City: | State: | | Zip: |
| Telephone: | Fax: | | County: |
| Website address: | | | |
| Executive Director: | | Email: | |
| Project Director *(if different)*: | | Email: | |
| Brief statement of organization’s objectives and/or activities | | | |
| Brief description of organization’s key accomplishments over the last two years. | | | |
| Describe how your organization supports Parkinson Support and Wellness. | | | |

**REQUEST SUMMARY**

|  |
| --- |
| Grant Program Period:  January through June  July through December 20\_\_ |
| Project/Program Title(s): |
| Select Wellness Focus Area(s): Physical Exercise Vocal Exercise Cognitive Exercise  Education  Support  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Type of Program/Project: New Program Existing Program Support  Existing Program Expansion  Project |
| Amount requested from Parkinson Support & Wellness (PSW): $ |

**Program Instructor(s) Qualifications**

The qualifications of the people who will work with patients to execute the program can be established and enhanced by education, training, and experience relevant to work with PD patients. We especially value Parkinson's specific training and encourage all staff to learn as much as they can about PD. Please give the following information for each instructor who will work with PD patients.

**Instructor Name:**

**Education**

Undergraduate degree in exercise-related field

Undergraduate degree in another health-related field

Graduate degree in exercise-related field

Graduate degree in physical therapy

Graduate degree in another health-related field

On-the-job training

Continuing education (course or conference in last 5 years where you learned about Parkinson’s please give topic and date):

**PD-specific training (resulting in certification) in a widely recognized PD-specific exercise method**

Dance for PD

Delay the Disease

Parkinson Wellness Recovery

LSVT BIG

Brain Grant's Exercise for Parkinson's Training for Professionals

Parkinson’s Training for Fitness, Health and Wellness Professionals (APDA)

Rock Steady Boxing

Allied Team Training for Parkinson's  (Parkinson’s Foundation)

Parkinson Voice Project: Speak Out and Loud Crowd

LSVT Loud

**Experience**

Number of years of experience working with PD patients

Other relevant experience (explain)

**PROJECT/PROGRAM SUMMARY**

|  |
| --- |
| Provide a brief description of overall project/program(s) and objectives. |
| Have you made any changes to your program since the last grant period? If yes, please explain. |
| Describe how the grant will be spent. |
| Describe the program sustainability plan. |
| How will the project/program be marketed to increase attendance? |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Class** |  |  |  |  |
| Address, City, State, Zip |  |  |  |  |
| Day(s) of the Week |  |  |  |  |
| Start-End Time |  |  |  |  |
| # Sessions in grant term |  |  |  |  |
| Estimate number of PWPs for each class during the upcoming term? |  |  |  |  |
| Class capacity |  |  |  |  |
| **Participant Fees** |  |  |  |  |
| Fee per session PWPs | $ |  |  |  |
| Fee per session for others | $ |  |  |  |

*\*\*Note: If additional columns are needed to document all classes, please copy and paste the above table into the following page of this document.*

**Program Budget (Grant Period):**

**Income:** Participant Fees \_\_\_\_\_\_\_\_\_\_\_ + Other Sources \_\_\_\_\_\_\_\_\_\_ = \_\_\_\_\_\_\_\_\_\_\_

**Expense:** Line item expenses to deliver program

**RESULTS OF PRIOR FUNDING FOR EXISTING PROGRAMS  
*If applying for a Parkinson Support & Wellness (PSW) grant for the first time, skip this section.***

|  |
| --- |
| Month/year of last PSW grant. |
| How was the grant monies used to meet your program/project objective(s)? |
| How did the grant impact your project or program? |
| Describe how the project/program(s)was marketed and if strategies were effective. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PARTICIPATION PAST 4 MONTHS (ONGOING PROGRAMS ONLY)** | | | | |
| **Name of Class** | **#1** | **#2** | **#3** | **#4** |
| Avg.# of paying participants over last 4 months |  |  |  |  |
| 1/2019 |  |  |  |  |
| 2/2019 |  |  |  |  |
| 3/2019 |  |  |  |  |
| 4/2019 |  |  |  |  |

*\*\*Note: If additional columns are needed to document all classes, please copy and paste the above table into the following page of this document.*

**TERMS & CONDITIONS**

|  |  |  |
| --- | --- | --- |
| **These terms and conditions are applicable in the event that the request for funding is approved.**  ***An authorized signer from the host organization and the Program Director (if different) must initial each of the following. Typed initials are sufficient.*** | ***Host Initials*** | ***Program Director Initials*** |
| The Project is the sole responsibility of the Applicant and PSW will not provide design, direction or control over the Project. |  |  |
| Applicant and its employees are not employed or otherwise controlled by PSW. |  |  |
| PSW is a funding source only. |  |  |
| The Applicant shall not refer to PSW in any advertisements or communication materials other than to state: “Funding support provided in part by Parkinson’s Support & Wellness, Inc.” |  |  |
| Applicant certifies to PSW that it has sufficient other financial resources to complete the Project. |  |  |
| Applicant certifies to PSW that: (i) it has complete liability and casualty insurance coverage and that it will be in effect to cover the Project’s expected timeline, and (ii) the insurance, including worker’s compensation coverage, is sufficient to cover any losses or claims arising out of the Project, and upon the request of PSW, Applicant will provide written confirmation of the limits and type and kind of insurance and confirm it is in full force and effect. |  |  |
| Applicant indemnifies PSW, and its employees, agents and representatives, and holds PSW and their employees, agents and representatives, harmless from any and all losses, claims and obligations, of any type kind or character, including reasonable attorney’s fees and expenses, asserted against PSW or their employees, agents or representatives, arising out of or related to the Project. |  |  |
| Applicant represents and warrants that, if Application is approved and funding is provided by PSW, then such funding will only be used to benefit Persons with Parkinson’s (together with their caregivers) and that such funding will not be used to benefit, through discount, subsidy or otherwise, persons who are not PWP. |  |  |
| Applicant acknowledges and agrees that if the funding is used to offer classes or programs such as exercise, yoga or otherwise, then PWP will be given first preference to attend such classes or programs over all other persons. |  |  |
| At the conclusion of the Project the Applicant will provide to PSW upon request, information deemed appropriate by PSW such that PSW can assess the effectiveness of its mission as related to the Project. |  |  |
| The person signing for Applicant is duly authorized by the organization that person represents. |  |  |

**AUTHORIZATION SIGNATURE**  
If the request for funding is approved, the Applicant agrees: (i) to use the funds for the purposes listed above and only for the described Project, and (ii) under the terms and conditions imposed by PSW. A typed signature will be sufficient.

Signature:

Title:

Click or tap to enter a date.

**FUNDING TIMELINE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Application Deadline** | **Period Covered** | **Decision Released** | **Funds Transmitted** |
| October 15 | January 1 to June 30 | December 31 | December 31 |
| April 15 | July 1 to December 31 | June 30 | June 30 |

Email completed grant application to [info@parkinsoncincinnati.org](mailto:info@parkinsoncincinnati.org) or mail to Parkinson Support & Wellness, c/o Nancy Wetterer, 260 Stetson Street, Suite 2300, Cincinnati, OH 45219