



Central Chesapeake Region

# Family Fund Application

Fiscal Year 2018  
(July 1, 2017 - June 30, 2018)

## Applicant Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Parent/Guardian Information

Name: \_\_\_\_\_

Relationship to Grantee: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Please answer each question in as much detail as possible.**

**1) Please describe your family member's disability.**

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**2) Describe how the requested assistance will benefit your family.**

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**3) What additional information can you share with The Family Services Fund grantors to assist in evaluating this grant request and allocate funding to your family?**

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4) Please list below what service(s) you are requesting funding for.

TOTAL AMOUNT REQUESTED \$ \_\_\_\_\_

Type of Service	Cost	Amount You Can Contribute	Benefit of Service	Service Provider	Contact Information for Service Provider

5) Have you been awarded assistance through any other source this fiscal year (July 1, 2017-June 30, 2018)? If yes, please list the items requested and amounts received.

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6) If awarded funding, are you willing to be contacted by a staff in our Advancement Department to talk with them how these funds benefited your family?

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**Questions?**

Contact Marisa Sternberg, Personal Supports Manager  
410.990.1908 or [msternberg@thearcccr.org](mailto:msternberg@thearcccr.org)

**OFFICE USE ONLY**

Date received: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Amount approved: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date notified: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Approved by: \_\_\_\_\_