Colorado Fund for Muscular Dystrophy

13411 Twin Team Lane, Midlothian, VA 23113
coloradofmd@gmail.com

The Colorado Fund for Muscular Dystrophy (CFMD) was established in 2012 by friends and family of Aileen Colorado, who passed away from complication from pneumonia in 2011. Born with congenital muscular dystrophy, Aileen never let her disability stop her from living a fulfilling life and a career helping people with disabilities.

In memory of Aileen, CFMD made it their mission to increase the quality of life of individuals living with muscular dystrophy. In addition to sponsoring children to attend the Muscular Dystrophy Association Summer Camp in Wakefield, Virginia, CFMD offers grants to individuals with muscular dystrophy who are in need of financial assistance.

Grants may be awarded for, but not limited to, equipment or services such as assistive technology, therapies, medical supplies, home modifications, or recreation center membership.

Applicant must be a Virginia resident to be eligible for the grant.

The maximum request amount per application is $1,000, payable to a single vendor.

Grants may be awarded twice a year, depending on the availability of funds. Applications deadlines are **May 1 and October 1.**

If we cannot grant your request for assistance, we will make an effort to suggest other possible resources that may meet your needs.

Please mail or email the completed application with the required additional documentation to the address below. Applicants chosen to receive the grant will be notified by email or by phone.

Mail: Colorado Fund for Muscular Dystrophy
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Email: coloradofmd@gmail.com

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Name of person submitting application: _____

Relation to applicant: _____

Email address: _____

Phone number: _____

Name of applicant:_____

Date of Birth: _____

Address: _____

Specific Neuromuscular condition: _____

Describe how the medical condition affects activities of daily living: _____

_____

Requested item/service: _____

Description of how the item/services will provide assistance or benefit: _____

_____

_____

Cost of the item/service (Please include proof of cost -web link, invoice, etc): _____

Applicant currently receiving the following services (Check all that apply):

___Medicaid ____Medicare ___Supplemental Security Income

___ Dept of Social Services (describe services) _____

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____ Department for Aging and Rehabilitative Services (describe services) _____

____ Grants from other organizations (Amount/organization)_____

____Other financial resources _____

- **Please include a letter from the applicant's doctor verifying the muscular dystrophy and why applicant would benefit from item/services.**
- **Please include proof of cost of the item/service**
- Maximum amount of grant $1,000.
- Money will not be given directly to individuals. Money will be paid directly to the business providing the item or service.
- Financial assistance will not be awarded to pay off loans or debts.
- If we cannot grant your request for assistance, we will make an effort to suggest other possible resources that may meet your needs.
- All sensitive information provided on this application will be kept confidential and will not be sold or given to any third party for solicitation.

Signature of applicant: _____ Date _____

Signature of parent/legal guardian if applicant is under the age of 18: _____

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Release Form

By signing this agreement, I authorize the Colorado Fund for Muscular Dystrophy to use my photograph and my personal story in a wide variety of materials including newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits, and other prints and digital communication.

Name: _____(Please print)

Signature: _____

Signature of parent/legal guardian if under the age of 18:_____

Date: _____ Telephone #:_____

E-mail address: _____
(We will use your email address to contact you regarding questions and use of your story and testimonial)