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 Virginia. 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, therapies, medical supplies, home modifications, or recreation center membership, not fully covered by insurance.

Applicants must be a Virginia resident with a diagnosis of muscular dystrophy to be eligible for the grant.

The maximum request amount per application is $1,000, payable to a business. Grants will not be awarded to pay off loans/debts or as reimbursement of items/services already purchased.

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. Incomplete applications missing the required documents will not be considered for the grant.

Grants may be awarded annually, twice a year, depending on the availability of funds. Completed applications will be reviewed when received. Only applicants chosen to receive the grant will be notified by email or by phone.

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Name of person submitting application: _____

Relation to applicant: _____

Email address: _____

Phone number: _____

Name of applicant:_____

Date of Birth: _____

Address: _____

Type of Muscular Dystrophy: _____

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

_____

Requested item/service: _____

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

_____

_____

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

Grant amount requested (max $1,000): _____

If the price of the item/service is over $1,000, do you have funds to pay the remaining balance? YES NO

Money will not be given directly to individuals. Money will be paid directly to the business providing the item or service.

Name of business contact providing item/service: _____

Phone number of business contact: _____

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Persons with muscular dystrophy may be eligible for the following resources listed below. Please contact your local MDA clinic social worker for questions or assistance.

Resources (Please complete the section below)

Private Insurance- (List name of insurance company) _____

Medicaid
- ☐ Never applied
- ☐ Completed application and waiting for decision: Date completed application _____
- ☐ Denied benefits: List reason for denial _____
- ☐ Approved benefits: List benefits received _____

Medicare
- ☐ Never applied
- ☐ Completed application and waiting for decision: Date completed application _____
- ☐ Denied benefits: List reason for denial _____
- ☐ Approved benefits: List benefits received _____

Supplemental Security Income (low income individuals who have never worked)
- ☐ Never applied
- ☐ Completed application and waiting for decision: Date completed application _____
- ☐ Denied benefits: List reason for denial _____
- ☐ Approved benefits

Social Security Disability Insurance (those who have worked in the past)
- ☐ Never applied
- ☐ Completed application and waiting for decision: Date completed application _____
- ☐ Denied benefits: List reason for denial _____
- ☐ Approved benefits

Department of Social Services
- ☐ Never applied
- ☐ Completed application and waiting for decision: Date completed application _____
- ☐ Denied benefits: List reason for denial _____
- ☐ Approved benefits: List benefits received _____

Department for Aging and Rehabilitative Services
- ☐ Never applied
- ☐ Completed application and waiting for decision: Date completed application _____
- ☐ Denied benefits: List reason for denial _____
- ☐ Approved benefits: List benefits received _____

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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**
- Financial assistance will not be awarded to pay off loans/debts or as reimbursement of items/services already purchased
- 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: _____

Release Form

I hereby give my consent to the Colorado Fund for Muscular Dystrophy to use the following in press releases to the media, publications, or advertising activities if I am chosen as a recipient of the grant:

(Check the ones that you would allow)
- ☐ My name
- ☐ Diagnosed form of Muscular Dystrophy
- ☐ Name of the county where I reside
- ☐ Name and description of the service or item that was purchased with the grant
- ☐ Description of how the service/item has improved my quality of life
- ☐ Pictures I submit to CFMD

Applicant's Name: _____ (Please print) Date:_____

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

E-mail address: _____ Telephone #:_____