4 Jake's Sake Charitable Foundation
Financial Assistance Application

Date:
Name:
Address
City, State, Zip
Phone:
Email:

Parent / Guardian Information:

Name:
Address:
City, State, Zip
Phone:
Email:

Please provide brief summary of proposed use of requested funds:

Dollar amount requested: $
Name of provider:
Website of provider:
Phone Number/Contact of Provider:
Address of Provider:
Date funds required:

Duchenne Applicant Signature:

_____

Person completing application signature/relationship to applicant:

_____

Has requester ever received a grant from the foundation previously? Y N

Is requester an employee or affiliated with the foundation? Y N

Please sign and complete application and attach your doctors written letter confirming your Duchenne diagnosis and send to:

4 Jake's Sake Charitable Foundation
P.O. Box 238
Hudson, MA 01749

Note: Incomplete applications will not be eligible for grant approval.

Please allow up to 8 weeks for approval and disbursement of grant.

*** If your request is urgent, please note at top of first page of application.

Approvals:

_____ Date: _____

John Marrazzo – Trustee

_____ Date: _____

Sheryl Marrazzo – Trustee

_____ Date: _____

Margaret Robar – Trustee