



# *Handel Foundation*

*enhancing the quality of life of children and young adults with disabilities  
and their families*

## The Handel Foundation Grant Application

The Handel Foundation , in keeping with its mission, will offer funds to provide assistance with anything that directly improves the quality of life of children and young adults with special needs. The funding for this grant comes directly from Handel Foundation donations and fundraising. Grants will be offered for:

1. Medical expenses not covered by insurance or other conventional sources
2. Therapies including PT, OT, and Speech
3. Activities such as classes, camps, or organizations open to all children with and without disabilities
4. Educational classes, conferences, seminars or training sessions for applicant or family member that addresses issues pertinent to disabilities.
5. Adaptive equipment or home modifications

### Application process

Grants will be distributed within 30 days after approval. An independent grant committee will review all grant applications and determine fund distribution. Once determination is made, a letter will be sent notifying them of the decision and if accepted, a check will be mailed to the recipient.

Handel Foundation Grants are available to all children and young adults with disabilities and their families equally with no basis on financial status, color, race, or creed.

Complete the following form and mail or deliver to Handel Foundation c/o 721 Boardman Poland Rd., Suite 101, Boardman, Ohio 44512.

Direct any questions to Celeste Lisko ( Board Member) at 330-758-2424.

Recipients are asked to provide a picture and brief paragraph for possible Handel Foundation newsletter/website publication.

Complete Application and submit to Handel Foundation

Handel Foundation

721 Boardman Poland Rd., Suite 101

Boardman, Ohio 44512

**If Organization:** List Full Name \_\_\_\_\_

Is your organization \_\_\_ for profit \_\_\_ nonprofit \_\_\_ volunteer  
\_\_\_ other are you a 501c3?

Organization Contact name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Years in Operation \_\_\_\_\_

Reference / Passport Representative/Physician \_\_\_\_\_

**If Individual:** Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_

Activity/ Equipment for which you are seeking funds \_\_\_\_\_

Dates of Activity if applicable \_\_\_\_\_

Amount Requested \_\_\_\_\_

Providers Information:

Check made payable to: \_\_\_\_\_

Address \_\_\_\_\_

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

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_