Minnesota Organization on Fetal Alcohol Syndrome
FASD Support Fund Instructions

Through the generous sponsorship of the Saint Paul Foundation’s William and Connie Carroll Endowment Fund we are pleased to open the application process for the MO-FAS FASD Support Fund. The fund is currently restricted to serving families residing in the East Metro. The mission of the fund is to provide grant opportunities to families in Dakota, Ramsey, and Washington Counties caring for an individual known or suspected to be on the FASD spectrum, who need financial assistance for unmet needs, to reduce caregiver stress and improve the quality of life for the family. Please complete the form to apply for a grant from $100 up to $3,000 per individual from the fund. Only complete applications, with required supporting documentation, will be considered. If you are submitting applications for multiple individuals, a separate application is required for each applicant.

Grant Eligibility

- The individual receiving care must have a documented Fetal Alcohol Spectrum Disorder (FASD) Diagnosis. (For an individual suspected to be on the FASD spectrum, the family must provide confirmation that the individual has been diagnosed with a life-threatening illness or a mental or physical disability. Examples of eligible diagnoses include, but are not necessarily limited to Major Depressive Disorder, ADD, ADHD, Psychotic Disorders, Autism, Bipolar Disorder, Personality Disorders, Schizophrenia, Conduct Disorder, Reactive Attachment Disorder, Traumatic Brain Injury, Epilepsy, etc.).

- The caregiver and/or the individual receiving care must reside in Dakota, Ramsey, or Washington County.

Required Documents Checklist

- Fetal Alcohol Spectrum Disorders Diagnosis: Please provide a copy of your family member’s official FASD diagnosis or if you suspect your child is impacted by prenatal alcohol exposure, please include confirmation of a life-threatening illness or a mental or physical disability.

- Family Story: Not to exceed one page, please share why you are applying for a grant and how it will assist your family financially, how the services or equipment will benefit your family, and include any extenuating circumstances so that these may be taken into consideration.

- Financial Documents: A copy of your current 1040 (tax return) or SSI document (or other benefit summary) if not filing taxes. If documents do not have an address in the East Metro, provide a current copy of a utility bill as proof of residency.

- Invoice/Statement for equipment requests: Must indicate the exact amount of your request. Equipment requests must be an invoice/web cart and include; exact items, costs, and all taxes, plus shipping. AND/OR

- Contact Information for service requests: Please provide the details of whom to make the check out too if awarded; and include at minimum business name, contact person, email, address, and phone.

Submit complete applications with supporting documentation via e-mail to ruth@mofas.org or via U.S. mail:

Ruth Richardson, Director of Programs
Minnesota Organization on Fetal Alcohol Syndrome
2233 University Avenue West, Suite 395
Saint Paul, Minnesota, 55114

- Preference will be given to families with financial need, extenuating circumstances are considered.

- Grants will only be considered if the application is complete and all required documentation is provided.

- Once your complete application has been received, you will be notified a confirmation of receipt. The application will be considered at the next committee meeting. You will be contacted via phone and/or email with your outcome. Families may apply once every 12 months from the date of the previous award.

- We cannot provide grants for reimbursement for an item already purchased, services previously rendered, or any item or service where a government agency has the responsibility to provide the service or item.

If awarded a grant, typically grant funds will be paid directly to the provider, vendor, retailer, or organization listed on the application. In rare circumstances, payments may be made directly to a family, but that will require confirmation that funds were used appropriately. Once awarded your request cannot change.
MOFAS FASD Support Fund Application

Please refer to the instruction page for required accompanying documentation. Only complete applications will be considered. Please complete all fields.

Name of Individual Receiving Care: ________________________________

Date of Birth: ________________________________

Race/Ethnicity: (please circle all that apply)
- American Indian or Alaska Native
- Asian or Pacific Islander
- Black or African American
- Latino
- White
- Multi-Racial/Ethnic group
- Other: ________________________________

Street Address: ________________________________

City: ________________________________

ZIP Code: _______ Phone: (_____) ____________________

County of Residence: ________________________________

Does the individual receiving care have an FASD diagnosis?
YES NO

If not, does the individual receiving care have a suspected diagnosis and confirmation of a life-threatening illness or a mental or physical disability?
YES NO

Please specify the life-threatening illness or mental or physical disability:

______________________________

Age at time of diagnosis: ________________________________

Is the applicant a previous FASD Support Fund recipient?
YES NO

If yes, please list the last award date: ________________________________

What is your relationship to the individual receiving care:
(please circle)
- Parent
- Guardian
- Foster Parent
- Grandparent
- Sibling
- Spouse/Domestic Partner
- Other**

**Please explain: ________________________________

Are you a primary caregiver to the individual receiving care?
YES NO

Does the caregiver live with the individual receiving care?
YES NO

If no, then who does the individual receiving care live with?

______________________________

If the individual is over 18, do you have guardianship?
YES NO

Are you employed?
YES NO

How did you hear about the Family Support Grant Fund:
(please circle)
- MOFAS Website
- MOFAS Newsletter
- MOFAS Flyer
- MOFAS Virtual Family Center
- MOFAS Staff
- Friend/Family Member
- Professional (teacher, case manager, etc.)
- Other: ________________________________

Please indicate the FASD diagnosis. If the individual receiving care is not diagnosed with an FASD, please check N/A).

☐ Fetal Alcohol Syndrome (FAS)
☐ Partial Fetal Alcohol Syndrome (PFAS)
☐ Alcohol Related Neurodevelopmental Disorder (ARND)
☐ Alcohol Related Birth Defects (ARBD)
☐ Other: ________________________________
☐ N/A
Do you give permission for media coverage, if awarded?

YES    NO

Number of individuals in the caregiver’s household: _____

Please indicate the impact of caregiving (please circle):

- Social Strain
- Financial Strain
- Work Strain
- Health Strain
- Family Relationship Strain

Total amount of grant requested: $ ____________________

Service or Equipment Description:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you applied for this equipment or service with a governmental entity?

YES    NO

Have you received a denial from a governmental entity?

YES    NO

Office Use Only

Date Application Received:

Date Application Reviewed:

Disposition for Grant Funds: YES    NO

Reason: ________________________________

Amount Approved: $ ____________________

Date of Notification: ____________________

Comments:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Minnesota Organization on Fetal Alcohol Syndrome’s FASD Support Fund Terms and Conditions

I understand that submitting this application is no guarantee that I will receive a grant. Some of the reasons that my grant may be denied include but are not limited to lack of funds, incomplete application, or failure to fit into the criteria for the grant. MOFAS reserves the right to approve or deny grants as it deemed appropriate in its sole discretion.

I understand that I may be asked to provide additional documentation to substantiate my application. I also understand that the application will be shared with the MOFAS Family Support Fund Grant Committee in order to consider the requests.

I understand that I may receive less funds than I applied for. I understand and agree that if I am approved for a grant through the support fund, that I will be required to sign a copy of an agreement with the following terms and conditions prior to the grant funds being disbursed:

- I agree to complete a survey related to receiving grant funds.
- I understand that false or misleading information in my application may result in losing my grant if awarded, being required to return disbursed funds, and other actions against me.
- If awarded a grant, MOFAS will be held harmless from the outcomes from using the awarded service or equipment, nor are they responsible for additional expenses, replacement, installation, or maintenance.
- If I am unable to use the funds, checks must be sent back to MOFAS at which point you may be eligible to reapply for a different request.
- I understand and acknowledge that this grant fund are provided only in the event such equipment or services are not available through other government programs.
- I represent that all money will be used for the sole purpose documented on the application.
- The applicant understands and acknowledges that he/she must present and any other documentation to verify any expenses for which he/she requests payment.
- This agreement contains the entire agreement between the parties and there are no other promises or conditions in any other agreement, oral or written.
- This agreement may not be amended or modified except in writing signed by both parties.

I certify that I understand the terms and conditions of this grant fund, and that my answers are true and complete.

Signature: ________________________________

Partner Signature: ________________________________

Individual Receiving Care Signature: ________________________________

Please have the individual receiving care sign this document, if they are over the age of 18 and the caregiver does not have guardianship/conservatorship.