Dear ButterflyWish Grant Applicant:

Flutters of Hope Inc. was founded in 2019 by Annalise and Cheryl Marron to support others diagnosed with an eating disorder. At the young age of 11, Annalise grasped the high costs of treating an eating disorder and asked if we could one day assist others going through treatment. We are now pleased to offer **ButterflyWish Grants** to offset the associated costs of treatment in a residential facility or at home. These costs can include counseling, nutritionist fees, food supplements, a weighted blanket, travel expenses to visit a loved one in treatment, respite (babysitter), or family therapy.

Grant Eligibility:
Currently in treatment, at a residential facility or at home, for the following eating disorders: Anorexia, Bulimia, BED, PICA, Rumination, AFRID, or ED NOS.

Grant Application Criteria:

- A diagnosis by a physician stating that the individual is currently seeking treatment for an eating disorder.
- A complete and signed application (all questions must be answered).
- Attached receipts for reimbursement requests or estimates for impending expenses.

Grant Applications will be reviewed quarterly by the Board of Directors during a regular board meeting.
Flutters of Hope Inc. will award grants of up to $1,000.00 each quarter.
Flutters of Hope Inc. can award grants either by:
1) reimbursement for paid purchases or services (please attach receipts with the grant application);
2) paid directly to the provider; or
3) paid directly to the vendor for needed items.

Application Deadlines:
1st Quarter deadline: All application materials must be in by March 15th
2nd Quarter deadline: All application materials must be in by June 15th
3rd Quarter deadline: All application materials must be in by September 15th
4th Quarter deadline: All application materials must be in by December 15th

Please send your completed application and receipts to:
Flutters of Hope Inc.
Re: ButterflyWish Grant
11 Horseshoe Drive
Saratoga Springs, NY 12866
Or email your completed form and receipts to Cheryl at: hello@fluttersofhopeinc.org

Name of person in treatment: _____

Age: _____ **Date of Birth:** _____ **Gender:** _____ **Diagnosis:** _____

Name of Parent/Caregiver: _____

Address: _____

Email Address: _____

Phone: (H) _____
(C) _____

Please share why you are applying for a ButterflyWish Grant:

_____
_____
_____
_____

Please check what the money will be used for: _____ Treatment Cost _____ Goods and Services

Treatment: Please share the name of the treatment center and include a copy of the receipt:

_____
_____
_____

Goods and Services: Please share what you would like to be reimbursed for and include a copy of the receipt:

_____
_____
_____
_____

Total amount requested (up to $1,000)**:** _____

Gross family income: Please mark your income range.

_____ Under $30,000
_____ $30,000 - $50,000
_____ $50,000 - $80,000
_____ $80,000 - $100,000
_____ $100,000 - $150,000
_____ over $150,000

Signature: _____ **Date:** _____