Children’s Scoliosis Foundation Travel Grant

Financial aid grants of up to $500 per trip ($750 for international travel) are available to help support children and their families who are traveling long distances for bracing or surgical treatment for scoliosis.

Guidelines

1. Children must be under 18 years before the time of travel, be legal residents of the U.S. and have a diagnosis of scoliosis with curves measuring over 20 degrees. Non-U.S. applicants may apply through a local church or other nonprofit that is registered with the country of residence.

2. Only planned, upcoming medical trips to a bracing or surgical specialist are eligible for approval. Travel costs for exercise-based programs are not eligible.

3. Reasonable travel expenses for hotel, airfare, car rental, parking and gas for one child and one parent are eligible for reimbursement, up to $500 for a domestic trip and $750 for international travel. Meals and tips are not eligible for reimbursement. Grant funds will be released once the trip is complete and all copies of travel receipts are provided.

4. Funds may not be used for clinical care or any other non-travel related expense.

5. Family income must meet Federal Poverty Guidelines (below).

6. Applications will be reviewed and ranked based upon their demonstrated financial and medical need. Supporting documentation of financial need may be required.

Terms and Conditions

If financial support is received from other sources, or the trip cannot be completed, the applicant agrees to provide notification and withdraw the proposal. Copies of travel receipts must be provided within two weeks of trip completion in order to receive reimbursement.

Persons in Household	48 Contiguous States and D.C. Poverty Guidelines (Annual)	
	100%	400%
1	$12,140	$48,560
2	$16,460	$65,840
3	$20,780	$83,120
4	$25,100	$100,400
5	$29,420	$117,680
6	$33,740	$134,960
7	$38,060	$152,240
8	$42,380	$169,520
Add $4,320 for each person over 8		

Children’s Scoliosis Foundation Travel Grant Application

Patient Name ____ Date of Birth______________

Parent/Legal Guardian Name ____

Street Address ____

City ____ State _____ Zip Code _____________

Telephone ____________________________ Email____

Annual Household Income _____________________________ Number of Persons in Household ______

Clinic/Hospital________________________________ Name of Specialist ______________________________

Date of next scheduled visit?____

Briefly describe the diagnosis and treatments, future needs, and any other information that is relevant. Please enclose a copy of the most recent X-ray/MRI with your application.

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Statement of Understanding and Authorization

I have read, understand, and agree to abide by the terms and conditions and guidelines provided by the Children’s Scoliosis Foundation for the family medical travel grant application. I certify that all information that I have provided to the Foundation is accurate. I authorize the Children’s Scoliosis Foundation to discuss and share medical information provided with participating Foundation reviewers and current doctor for the purposes of evaluations.

Parent/Guardian Printed Name: ____

Parent/Guardian Signature: ____ Date: _______________

Mail completed application to: Children's Scoliosis Foundation, 10042 Wolf Rd., Suite B, #22, Grass Valley, CA 95949
Or email to: info@childrensscoliosisfoundation.org