

# The Finish Lyme 5k Grant for Lyme Treatment Assistance

Partner / Main Sponsor **Southern Tier Lyme Support Inc.**

**Deadline:** This application form and any other required documentation must be received by June 14th (11 p.m. eastern time). Mail to: The Finish Lyme 5K Grant for Lyme Treatment Assistance, 38 Blackstone Ave, Binghamton, NY 13903. Questions? Call Beth Scoville at (607) 427-2107 (5:00p.m. – 8:00 p.m. weekdays) or e-mail: thefinishlyme5kscholarship@aol.com.

**Required fields are indicated by an asterisk (\*).**

**Eligibility:** Applicants must meet these criteria to be eligible. Please initial or answer. You may answer on behalf of your minor. There is no age limit to the grant award.

1. \_\_\_\_\* How many years have you or your child had symptoms related to Lyme Disease?.
2. \_\_\_\_\* Have you or your child been diagnosed by a LLMD/MD/DO/NP?
3. \_\_\_\_\* What year were you or your child diagnosed with Lyme Disease?
4. \_\_\_\_\_\* What Lyme Literate Medical Dr do you or your child see?
5. \_\_\_\_\_\* What coinfections do you or your child have?
6. \_\_\_\_\* I live in the Northern Tier of PA State (counties include Susquehanna, Bradford, and Lackawanna. **OR**
7. \_\_\_\_\* I live in the Southern Tier of NY State (counties include Broome, Chenango, Tioga, Cortland, Delaware, Otsego, Schoharie, Tompkins, Chemung, Steuben, and Schuyler..
8. \_\_\_\_\* I have economic hardships that prohibit my being able to pay for proper Lyme Literate Dr. care which is not covered by insurance.
9. \_\_\_\_\* If chosen for a medical grant, I will utilize all funds for the purpose of treating my Lyme Disease. **In all grants the money will be made payable to the direct provider.**

**10.\*Name:**

a. First name\*-- Middle name(s) -- Last name\*:

b. \_\_\_\_\_  
If it is different than your formal name, what do you prefer to be called?:  
\_\_\_\_\_

Date of birth \_\_\_\_\_

7. **\*Home address:** The Finish Lyme Grant for Lyme Treatment Assistance is restricted to residents of the Southern Tier of NY State and Northern Tier of PA (See counties listed above).

\*Address: \_\_\_\_\_

Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*ZIP: \_\_\_\_\_

8. \*Primary telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

9. Secondary telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Extension: \_\_\_\_\_

10. E-mail: \_\_\_\_\_

11. Length of Illness. When were you first diagnosed with Lyme disease?

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12. If you have not had the financial ability to even be diagnosed properly yet please advise as well.

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13. \*Question (Paragraph): #1

What does the scholarship/ grant committee need to know about you in 300 words or less? The committee members will be especially interested in these points: How has Lyme Disease or symptoms of Lyme affected you personally and what would this assistance mean to you and your family?

14. \*Question (Paragraph) #2

Please tell us what you would use the grant money for! Money may be used for treatment by doctors/ clinics (/MD/DO/LLMD/LLND), medications and supplements. We will not award grants for any kind of assistive or adaptive equipment. **These grants will be paid directly to the provider of goods and services.**

Attach your essay to this form.

Financial award \$ amount is to be determined by funds raised and number of awards that can be given..

14. \*Certification Statement:

By signing my name below, I confirm that all of the information provided above and in the accompanying documents is true and correct to the best of my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_