



BENEFICIARY ELIGIBILITY APPLICATION

BENEFICIARY INFORMATION:

First Name:	Last Name:	Date of Birth (xx/xx/xxxx):
Home Address (Street, City, State, Zip):		
Date of Injury:	Place of Injury (Show Name, Facility Name, etc):	Age (at Time of Injury):
Description of the Beneficiary's Equestrian-Related Accident and Medical Diagnosis: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
Dollar Amount of Grant Request:	Name(s) of Entity or Entities to Receive Grant:	
Description of the Way(s) with which Beneficiary Plans to Use Grant Requested (i.e. medical costs, ADA equipment, etc): <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		

I understand and agree that the beneficiary is not a key member or an immediate relative of a key member of the Board of Directors and Administrator of the Kevin Babington Foundation. Further, I understand and agree that the entity in receipt of any/all grant(s) from the Kevin Babington Foundation is not a direct employee or contractor of the Kevin Babington Foundation. I understand and agree that any grant dollars awarded to the beneficiary will be used for the sole purpose of medical evaluation, medical care and/or ADA equipment that the beneficiary requires to facilitate his/her continued treatment since the onset of injury.

APPLICANT INFORMATION:

First Name:	Last Name:	Relationship to Beneficiary:
Applicant Signature:		

KBF Office Use Only

Date Application Received:	Dollar Amount of Grant Awarded:	Date Grant Paid Out:
Board of Directors Votes (Approved or Not Approved): MH: _____ JB: _____ DK: _____ MC: _____ SS: _____ JM: _____ CM: _____		

please return completed application to: contact@kevinbabingtonfoundation.org
 questions: please call (561) 301-5302