



Prader-Willi Syndrome Clinics Funding Application Form Year 2024

Grant Mechanism: Six months; up to \$8000
Funding Period: July 1, 2025 – December 31, 2025

Established by: This fund was established by the PWCF Board of Directors to support the development and functioning of multi-disciplinary clinics that serve individuals with Prader-Willi syndrome in the state of California.

Open to: Multi-disciplinary clinics that provide services to individuals with PWS in the state of California.

Criteria: Clinic has a multi-disciplinary team including at least three or more of the following specialists: social worker, registered dietitian, behavioral specialist, physical therapist, a physician with expertise in endocrinology and/or genetics.

Application Procedure:

- 1) Complete the grant application (answering all questions and signing the application)
- 2) Provide a Clinic Statement (2-page double-space 12 pt. font maximum) describing clinic goals and impact on quality of life of individuals with PWS and how this grant will help maintain or enhance clinic services.
- 3) Provide a 2-page curriculum vitae or resume of the clinic director or grant applicant documenting current and/or past involvement in serving the PWS community.
- 4) Provided an itemized budget of up to \$6,000/6 months and a budget justification. Include a description of other sources of funding for the clinic (in-kind or sponsored) to document the feasibility of the clinic functioning during the proposed period.

Application Timeline:

June 24, 2025: Full application due by 5pm PST info@pwcf.org.
July 1, 2025: Anticipated funding start date.

Please submit complete application and attachments to:

Prader-Willi California Foundation
Attn: Research Committee
P.O Box 370085
San Diego, CA 92137

Or email to: info@pwcf.org

*Prader-Willi California Foundation is a 501(c)(3) non-profit charitable organization.
All gifts are tax-deductible to the extent permitted by law.
Federal Tax Identification Number 95-3480752*

P.O. Box 370085 | San Diego, CA 92137

310.372.5053 | 800.400.9994 Toll-Free | Fax 310.372.4329 | info@pwcf.org | www.PWCF.org



Prader-Willi Syndrome Clinic Application

Physician's Name:

Address:

Phone:

City, State:

Zip Code:

Physician's Email:

Hosting Hospital or Facility:

Address:

Phone:

City, State:

Zip Code:

Clinic meeting days and hours:

Total number of patients served during the past year:

Age range of patients served:

Services provided:

- 1)
- 2)
- 3)

Role of applicant (director, administrator, etc.):

Clinic personnel (list name, role and % of time dedication):

- 1)
- 2)
- 3)

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Expenses: if no budget is requested in this application, indicate if an in-kind support is received and where is it coming from.

Budget Expenses:

Space rental (monthly or annually):

Personnel's Salary:

Consumables used in the clinic:

Other:

By signing and dating below, I affirm that the information given above is correct. I also understand that if awarded the grant the condition of acceptance is that I will write a report of the activities carried out and individuals served in the clinic between July – December 2025.

Applicant signature

Date

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