



## Prader-Willi Syndrome Clinics Funding Application Form Year 2022

**Number of Clinics to be funded:** To be determined by the 2022 PWCF Board of Directors

**Funding Amount:** up to \$5,000

**Period of Funding:** January 1<sup>st</sup>, 2022 to December 31<sup>st</sup>, 2022.

**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 \$5,000 and a budget justification. Include a description of other sources of funding for the clinic (in-kind or sponsored) to document feasibility of the clinic functioning during the proposed period.

**Application Deadline: March 15, 2022 for funding by April 1, 2022**

Please submit complete application and attachments to:

Prader-Willi California Foundation  
Attn: Research Committee  
1855 First Avenue Suite 201  
San Diego, CA, 92101  
Or email to: [info@pwcf.org](mailto:info@pwcf.org)

**Grant awardees notification:** April, 1st 2022

*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*

1855 First Avenue | Suite 201 | San Diego, CA 92101

310.372.5053 | 800.400.9994 Toll-Free | Fax 310.372.4329 | [info@pwcf.org](mailto:info@pwcf.org) | [www.PWCF.org](http://www.PWCF.org)



**Grant report guidelines:** Upon completion of the funding the main applicant should submit a report of the activities carried out and individuals served in the clinic for the funded period (January to December 2021). The report is due to PWCF on January 30<sup>th</sup>, 2022. In addition, submit the completed PWCF clinic funded satisfaction surveys. Please let PWCF know if you need more of these or any other informational materials.

### **PWCF CLINIC REPORT GUIDELINES**

The report must include:

- 1) Number of individuals served during the year the grant was awarded (January to December 2021) and the age-range of these patients.
- 2) Number of clinic visits provided during the year the grant was awarded (January to December 2021)
- 3) Number of contact hours with patients during the year the grant was awarded (January to December 2021) including the breakdown of number of visits with the different providers. For example, during 2020 the clinic provided 30 visits with a registered dietitian, 40 visits with the endocrinologist, 10 visits with a neurologist, etc.
- 4) A detailed breakdown as to how the money was allocated (used) including salary, rental facility fee, consumables, etc.
- 5) Indicate if any money was not used and the plan for use during the following year.

### **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:**

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**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.):** director

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

- 1)
- 2)
- 3)

**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:**

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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 January-December 2021.

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Applicant signature

Date

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