85 Elizabeth Street, RR2
Sutton West, Ontario
Canada, L0E 1R0
Telephone: 1-877-603-9991
Fax: 1-877-603-9991

www.giveamiracleachance.com

Supporting Children with Cerebral Palsy

Welcome to Give A Miracle A Chance!

We are pleased that you have chosen our Non-Profit Organization to assist your child.

Lynn Marles, our Executive Director began this organization in 2006, to help support her Grandson Denton, when they discovered that there would be no outside assistance available to help enrich his life and help support his needs for the coming future. With alot of research Lynn, Courtney and Steven (Denton's parents) found alternative treatment options for CP, and a successful fund raising campaign supported by friends and family have made it possible for Denton to participate. He has far surpassed doctor expectations, and reached milestones beyond the original diagnosis.

Give a Miracle a Chance (GAME) was borne based on Denton's outstanding improvement. We want to share our success with you. Denton's Family and friends decided to continue their ongoing support, and go one step further to include other children in their efforts. "Reaching out" in Canada and internationally, GAME works to support other families, to raise funds through community events, to open doors for other children, with the same support and commitment that saved Denton's life.

Should you or your family have any questions, or concerns, we are here to help. Please don't hesitate to contact us either through the web site, or using any of the telephone numbers available to you. Please note that funding must be pre-approved.

If you are filling the forms out on the computer, the highlighted areas will automatically fill in on each form. You may mail the original, email or fax your application packages.

To move to the next stage, just click CHECK LIST

OFFICE	CONTACT	
EXECUTIVE DIRECTOR	LYNN MARLES	lynn@giveamiracleachance.com
FAMILY LIAISON DIRECTOR	LINDA HOBBS	linda@giveamiracleachance.com

Please note our Policies and Procedures are subject to change without notification. Give a Miracle a Chance respects your privacy.

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Give A Miracle a Chance

Supporting Children with Cerebral Palsy

FORMS CHECK LIST

REGISTRATION NUMBER 0 -2008

Issued by Organization

CLICK ↓ WELCOME

RECIPIENT		
0	0	0
Last Name	First Name	Initial

	"X" ↓		"X" ↓
PARENT	**0**	**GUARDIAN**	**0**
0	0	0	0
Last Name		First Name	Initial

DOCUMENT NAME	DOCUMENT NUMBER			RECEIVED YES	RECEIVED NO
Click on Document Name				For Office Use Only	
Document Check List	**DCL**	**-**	**001**		
Recipient Criteria List	**RCL**	**-**	**002**		
Application Form	**APP**	**-**	**003**		
Audio/Visual Release Form	**AVF**	**-**	**004**		
Memorandum of Agreement	**MOA**	**-**	**005**		
Medical Information	**MED**	**-**	**006**		
Additional Information	**ADD**	**-**	**007**		
Fund Raising Participation	**FRP**	**-**	**008**		
Program Registration	**REG**	**Provided by Applicant**			
Receipt of Enrollment	**REC**	**Provided by Applicant**			
Certificate of Completion ACP	**ACP**	**Provided by Applicant**			
Income Tax Notice Previous Tax Year	**TAX**	**Provided by Applicant**			
Proof of Guardianship	**GUA**	**Provided by Applicant**			

Please review all documentation against the check list. This will ensure speedy processing of your application.

We look forward to assisting you and your child to lead a healthier, happier life together.

Contact:

Linda Hobbs, Family Liaison Director
e-mail: linda@giveamiracleachance.com
85 Elizabeth Street, RR2
Sutton West, Ontario Telephone: 1-877-603-9991
Canada, L0E 1R0 Fax: 1-877-603-9991

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Give A Miracle a Chance

Supporting Children with Cerebral Palsy

APPLICATION FORM - All funding must be pre-approved

REGISTRATION NUMBER [ ] -2009

Issued by Organization

RECIPIENT		
Last Name	First Name	Initial
Street Address	Apt. #	
City	Province/State	Postal/Zip Code
Country		

	Area Code	Number
TELEPHONE:		
FAX:		
BIRTH DATE	DAY	MONTH / YEAR
GENDER		

CHECK ↓ CHECK ↓

PARENT [ ]	**GUARDIAN** [ ]	
Last Name	First Name	Initial
Street Address	Apt. #	
City	Province/State	Postal/Zip Code
Country		

	Area Code	Number
TELEPHONE:		
FAX:		
CELL:		
EMERGENCY:		
EMAIL:		

ALTERNATIVE TREATMENT PROGRAM

REQUESTED PROGRAM [ ] [ ] [ ] [ ]

TREATMENT DATE: DAY MONTH YEAR Proof of Registration / Attach Copy

	PARTIAL	**FULL**	**NOT SURE**		**YES ($)**	**NO**
FUNDING REQUIRED:				DEPOSIT PAID TO CAMP?		

PARENT / GUARDIAN AUTHORIZATION

Print Name _____ Signature _____ Date _____

Please complete all forms and forward to Family Liaison Director at the address above.

PARENT/GUARDIAN COMMENTS:

Please provide details of the condition of the recipient and expectations of the treatment.
If additional space is required please attach a separate document to the form.

CLICK ↓
MORE INFO

Once completed click to next step
CLICK ↓
CHECK LIST

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Supporting Children with Cerebral Palsy

RECIPIENT CRITERIA LIST

REGISTRATION NUMBER 0-2009
Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓ 0

PARENT		GUARDIAN	CHECK ↓ 0
0		0	0
Last Name		First Name	Initial

At ***Give a Miracle a Chance,*** we value the children of today as the future of tomorrow. We believe that awareness and humanitarian kindness can be encouraged at a young age to establish a firm foundation for future years.

The ***Give a Miracle a Chance*** organization assists families by reaching out to children with Cerebral Palsy (CP) to offer hope and support for a viable future. We offer education and research to families as well as reach out to provide assistance in meeting the financial needs for independent CP treatments.

We will consider requests for assistance in the following areas:

- Financial Assistance for alternative Cerebral Palsy treatments
- Mentorship and Family Support Program
- Family Support Resource Library
- Educational programs, materials, and instruction

To qualify as a successful candidate you must provide the following:

Document Check List	**DCL**	**-**	**001**
Recipient Criteria List	**RCL**	**-**	**002**
Application Form	**APP**	**-**	**003**
Audio/Visual Release Form	**AVF**	**-**	**004**
Memorandum of Agreement	**MOA**	**-**	**005**
Medical Information	**MED**	**-**	**006**
Additional Information	**ADD**	**-**	**007**
Fund Raising Participation	**FRP**	**-**	**008**
Program Registration	**REG**	**Provided by Applicant**	
Receipt of Enrollment	**REC**	**Provided by Applicant**	
Certificate of Completion ACP	**ACP**	**Provided by Applicant**	
Proof of Guardianship	**GUA**	**Provided by Applicant**	

Eligible Recipient Requirements:

- **Registered candidate must be signed up for treatment by Give A Miracle a Chance 60 days before your choice of program begins to be eligible.**
- Due negligence to not register within the time frame will result in the funds forfeited.
- Cancelled treatments will require forty-five (45) days notice, prior to enrollment date.
- Memorandum of Agreement (MOA) between parent/guardian & the organization.
- Authorized original signed copy of the Audio-Visual Release form
- Authorized original signed copy of the Medical Form
- Active participation by the parent/guardian with the benefit fund raising events. (To be negotiated on individual basis, pending geographic location in which the recipient resides.)

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Supporting Children with Cerebral Palsy

RECIPIENT CRITERIA LIST

REGISTRATION NUMBER 0-2009

Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓ 0

CHECK ↓ 0

PARENT		GUARDIAN	
0		0	0
Last Name		First Name	Initial

Application Process:

Completed application packages will be reviewed by an Advisory Board to determine the eligibility of the submitted applications packages. Qualified candidates will be notified in writing by the organization.

In order to help prioritize our funding and resources, and to help those with the greatest financial needs, we will at this time only consider applications from families with combined annual incomes of less than $65,000 gross (before taxes). If applications exceed funding available, applicants may be required to prove eligibility.

Please contact the treatment centre you have chosen and confirm dates, prior to applying to Give a Miracle a Chance. Once you have done so, fill out the forms and forward them with the camp dates you require. We will then contact the camp and confirm the dates and amounts, set up the confirmations and advise you within 14 days from receipt of your application as to your acceptance to the camp.

You can access the camp websites from www.giveamiracleachance.com website.

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Give A Miracle a Chance

Supporting Children with Cerebral Palsy

MEDICAL INFORMATION

REGISTRATION NUMBER 0-2009
Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓ CHECK ↓

PARENT	0	GUARDIAN	0
0		0	0
Last Name		First Name	Initial

PHYSICIAN INFORMATION

Last Name	First Name	Initial

Signature

City	Province	Postal Code

CELL: Area Code | Number

TELEPHONE:

EMERGENCY:

FAX:

EMAIL:

CHECK ↓

CEREBRAL PALSY DIAGNOSIS (To be completed by Physician)	**See attached**	

If addditional space requried please attached a serparate sheet and indicate the form number

Physician's Name (Please Print)

Physician's Signature

Date

Include the Medical Form with the Application Package. Original or faxed copies are accepted.

Contact:
Linda Hobbs, Family Liaison Director
e-mail: linda@giveamiracleachance.com

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Supporting Children with Cerebral Palsy

AUDIO VISUAL RELEASE FORM

REGISTRATION NUMBER 0 -2009

Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓		CHECK ↓	
PARENT	**0**	**GUARDIAN**	**0**
0	0	0	
Last Name	First Name	Initial	

I understand that by authorizing this Audio Visual Release form, on behalf of _____
Insert Recipient Name

I am irrevocably releasing the use of any likeness dialogue which has been recorded of _____
for the by Give A Miracle A Chance organization, including its' employees, agents, or servants for any multi media purpose that could include reproducing it on our web site, or any other printed media associated with the organization, such as promotions, single images, or as wallpaper.

All audio visual records, recordings, negatives and/or slides together with any prints shall constitute the property of Give A Miracle A Chance, solely and completely.

Give a Miracle A Chance respects your privacy. We protect your personal information and adhere to all legislative requirements in protecting your privacy. We do not rent, sell, or trade our mailing lists. We use your personal information to provide services to keep you informed and up to date on our activities.

PRINT NAME _____ **SIGNATURE** _____

DATE _____

Please be sure to include this form in your Application Package.

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Supporting Children with Cerebral Palsy

MEMORANDUM OF AGREEMENT (MOA)

REGISTRATION NUMBER 0-2009
Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓		CHECK ↓	
PARENT	0	GUARDIAN	0
0		0	0
Last Name		First Name	Initial

GIVE A MIRACLE A CHANCE		
Last Name	First Name	Initial

Parties to this agreement:

This agreement is made between Give A Miracle A Chance; herein addressed as "The Organization", the Parent/Guardian, and the Recipient. Both parties, The Organization and the Parent/Guardian are signatures to this agreement, including any amendment or termination thereof.

Purpose of this agreement:

The purpose of this agreement is to outline the responsibility, accountability, and general principles for delivering the guarantee of enrollment for the recipient, into the approved program.

Approved Program: Ability Camp Hyperbaric Oxygen and Conductive Education Program

The Scope will include: (also refer to check list)

Document Check List	DCL	-	001
Recipient Criteria List	RCL	-	002
Application Form	APP	-	003
Audio/Visual Release Form	AVF	-	004
Memorandum of Agreement	MOA	-	005
Medical Information	MED	-	006
Additional Information	ADD	-	007
Fund Raising Participation	FRP	-	008
Program Registration	REG	Provided by Applicant	
Receipt of Enrollment	REC	Provided by Applicant	
Certificate of Completion ACP	ACP	Provided by Applicant	
Income Tax Notice	TAX	Provided by Applicant	
Proof of Guardianship	GUA	Provided by Applicant	

Time Period:

MEMORANDUM OF AGREEMENT (MOA)

REGISTRATION NUMBER 0 -2009

Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓ CHECK ↓

PARENT	0	GUARDIAN	0
0		0	0
Last Name		First Name	Initial

This Memorandum of Agreement (MOA) is effective and binding from the date of signature, for a period of twenty-one (21) months.

Principles:

- Maintain an ongoing and open communication with all parties.
- Issues and disputes will be dealt with in a constructive, respectful and timely manner.
- Maintain a high level of compliance of confidentiality between the organization, the recipient, and the parent/guardian
- Period of eligibility is effective within the dates of _____ (Month / Day / Year) _____ (Month / Day / Year)
- Funds released on behalf of eligible recipients are specifically for treatment offered at the approved treatment/therapy program
- Eligible recipients will be notified in writing by _____ (Month / Day / Year)
- Any disputes or discrepancies by the Parent/Guardian are to be addressed in writing directly to the Director of the Organization.
- Any disputes or discrepancies by the Organization are to be addressed in writing directly to the Parent/ Guardian, by the Director of the Organization and/or Project Sponsor.

Roles:

- Respective Parent/Guardian will sign and provide an original or faxed copy of the required documents as stated on the Recipient Check List.
- Respective Parent/Guardian will provide photographs and/or videos to the Organization for the duration of the agreement.
- The Organization and the Parent/Guardian will be in compliance of the stated terms and conditions of the agreement at all times.
- The Organization will transfer agreed upon funds to the approved program, on behalf of the recipient, providing all conditions of enrollment and eligibility are met within the dates agreed to.
- Approved Recipient must be enrolled in the program no later than _____ (Month / Day / Year) to ensure placement in the scheduled program.
- If the Recipient is not registered and approved by said date, funds will be forfeited and provided to another eligible Recipient. The Organization will notify the Parent/Guardian/Recipient by Registered Mail 10 days prior to the final registration date, that the registration has not been received and is in jeopardy of being cancelled should we (the Organization) not receive finalization in the next 72 hrs.
- In the event that the Recipient will not be attending the program, the Parent/Guardian is responsible to notify the Organization accordingly, in writing, via Registered Mail, Forty-five (45) days prior to enrollment date.
- Parents/Guardians are to actively participate with community fund-raising events. Terms and conditions for 'active' participation will be negotiated on an individual basis pending the geographic location where the recipient resides.

Approvals and Agreements:

MEMORANDUM OF AGREEMENT (MOA)

REGISTRATION NUMBER 0 -2009

Issued by Organization

CLICK ↓ CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓ CHECK ↓

PARENT	0	GUARDIAN	0
0		0	0
Last Name		First Name	Initial

Give A Miracle A Chance

Signature

Lynn Marles, Executive Director

Month / Day / Year

Signature

Month / Day / Year

Recipient (if over the age of 18)

Parent / Guardian

Signature

Month / Day / Year

Give a Miracle A Chance respects your privacy. We protect your personal information and adhere to all legislative requirements in protecting your privacy. We do not rent, sell, or trade our mailing lists. We use your personal information to provide services to keep you informed and up to date on our activities.

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Give A Miracle a Chance

Supporting Children with Cerebral Palsy

ADDITIONAL INFORMATION

REGISTRATION NUMBER 0-2009

Issued by Organization

CLICK ↓
CHECK LIST

RECIPIENT		
0	0	0
Last Name	First Name	Initial

CHECK ↓ CHECK ↓

PARENT	0	GUARDIAN	0
0		0	0
Last Name		First Name	Initial