

## **Harrison-Conrad Memorial Trust**

Financial assistance for the medical care of children in Loudoun County

PO Box 304  
Leesburg, VA 20178  
Susan Singh, Coordinator

The Harrison-Conrad Memorial Trust was established under the will for Mary J. Conrad. Under the terms of her will, those individuals who are potential beneficiaries of the trust are "children from the Town of Leesburg or Loudoun County suffering from polio or muscular dystrophy or any other crippling diseases, restricted to those cases in which the family cannot afford to provide for such expenses." More plainly stated, the HCT offers financial assistance for the medical care, treatment, equipment and supplies for needy children with disabilities in Loudoun County, Virginia.

To further clarify, the Court has defined "crippling disease" as "an impairment of the normal state of a child that interrupts or modifies the performance of the vital functions, being a response to environmental factors (as malnutrition, industrial hazards, or climate), to specific infective agents (as worms, bacteria, or viruses), to inherent defects of the organism (as various genetic anomalies), or to combinations of these factors, and which Requires treatment, medical care or hospitalization.

The basic guidelines of the Trust are as follows:

- Beneficiary must have a disability
- Beneficiary must be under the age of eighteen years
- Beneficiary must live in Loudoun County, Virginia
- The family of the beneficiary must be in financial need

Application is made through a written application form, which can be obtained from the Coordinator of the Trust. This application outlines the needs of the child, the cost of these needs and the financial condition of the family. A new application must be submitted each time a request is made. It is beneficial to include any professional evaluation of the child's needs and as much information as possible concerning equipment.

Qualified 501(c)(3) organizations who care for or work with children with disabilities may also apply by written proposal. It is the priority of the Trust to meet individual needs before funding the needs of organizations.

The applications are presented by the coordinator to a Selection Committee. This committee meets approximately five times per year: January, March, May, July and October. The members of this Selection Committee carefully review each application. A decision is reached based on the criteria listed above plus availability of funds. If funds are not approved for a particular need, the family may submit a new application to be considered at the next Committee meeting. The applicants will be informed promptly of the Committee's decision.

For more information, contact Susan Singh, Trust Coordinator at 703-779-0307.

**APPLICATION**

HARRISON-CONRAD MEMORIAL TRUST  
P.O. BOX 304 - LEESBURG, VIRGINIA 20178-0304  
PHONE: (703) 779-0307

The Harrison-Conrad Memorial Trust was established under the will of Mary J. Conrad. Its purpose is to offer financial assistance for medical treatment, supplies and equipment for needy children with disabilities.

The child receiving the benefit must be under eighteen years of age and a resident of Loudoun County.

An application form must be completed each time a request is submitted.

Date of Application: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_

List all members of the household, their age and relationship to the child (please include photograph if possible): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Describe the child's disability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the specific need that the requested service or equipment will meet and how it will benefit the child. Include any reports from professionals that support this petition. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the specific items / services needed and the cost of each. In the column marked "FAMILY CONTRIBUTION" indicate the amount that you can contribute to this particular item.

ITEM OR SERVICE	TOTAL COST	REQUESTED	FAMILY CONTRUBUTION
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____

How soon do these needs have to be met? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the child covered under any health or medical insurance?  
\_\_\_\_\_  
\_\_\_\_\_

If yes, please give company name and kind of coverage: \_\_\_\_\_  
\_\_\_\_\_

Will the insurance cover any part of the requested item or service?  
How much? If not, why? \_\_\_\_\_  
\_\_\_\_\_

Have you tried to negotiate with your insurance company or sought assistance in doing so? \_\_\_\_\_  
\_\_\_\_\_

Is the child enrolled in any Special Education Program or Therapeutic Programs? \_\_\_\_\_

If yes, please list the name of the facility and a contact person: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List other funding sources explored and note the reason why the source would not fund all or part of the request: \_\_\_\_\_

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## MONTHLY INCOME AND EXPENSE STATEMENT

Gross Monthly Income #1\*: \_\_\_\_\_ Gross Monthly Income #2\*: \_\_\_\_\_

Less deductions:

F.I.C.A. \_\_\_\_\_

Fed. Taxes \_\_\_\_\_

State Taxes \_\_\_\_\_

Insurance \_\_\_\_\_

Other \_\_\_\_\_

Net Income: \_\_\_\_\_

Less deductions:

F.I.C.A. \_\_\_\_\_

Fed. Taxes \_\_\_\_\_

State Taxes \_\_\_\_\_

Insurance \_\_\_\_\_

Other \_\_\_\_\_

Net Income: \_\_\_\_\_

List other sources of income and monthly amount: \_\_\_\_\_

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**\*VERIFICATION OF INCOME IS REQUIRED. PLEASE SUBMIT WITH THIS APPLICATION A COPY OF YOUR LAST INCOME TAX RETURN AND TWO RECENT PAY STUBS. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION. THE COPY OF THE LAST TAX RETURN MUST BE A COMPLETE COPY, NOT JUST THE FIRST FEW PAGES.**

MONTHLY EXPENSES:

\$ _____ Rent / House payments	\$ _____ Food
\$ _____ Electricity	\$ _____ Loans
\$ _____ Telephone	\$ _____ Charge Accounts
\$ _____ Fuel / Oil	\$ _____ Other (please specify)
\$ _____ Gas	\$ _____ Water / Sewer
\$ _____ Other (please specify)	\$ _____ Car Insurance
\$ _____ Health Insurance	\$ _____ Home Insurance
\$ _____ Medication	

\$ \_\_\_\_\_ **Total Monthly Expenses**

**ASSETS:**

House (Fair Market Value) \$ \_\_\_\_\_  
Other Real Estate \$ \_\_\_\_\_  
Bank Accts, CD's \$ \_\_\_\_\_  
Stocks, Bond, Securities \$ \_\_\_\_\_  
Life Insurance (cash value) \$ \_\_\_\_\_

401K, IRA's, Pension,  
Profit Sharing \$ \_\_\_\_\_  
Motor Vehicles \$ \_\_\_\_\_  
Other Assets \$ \_\_\_\_\_  
\$ \_\_\_\_\_

**TOTAL ASSETS \$ \_\_\_\_\_**

**LIABILITIES (DEBTS):**

House Mortgages \$ \_\_\_\_\_  
Other Mortgages \$ \_\_\_\_\_  
Car Loans \$ \_\_\_\_\_  
Credit Card Balances \$ \_\_\_\_\_  
Charge Accounts \$ \_\_\_\_\_

Other Debts \$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_

**TOTAL DEBT \$ \_\_\_\_\_**

Please state major expenditures in the last year as a result of your child's disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please include any additional information concerning your child's needs that may be helpful to the Harrison-Conrad Memorial Trust Selection Committee in considering your application: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referral Source: \_\_\_\_\_  
Application Completed By: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**RELEASE OF INFORMATION**

The information in this application is true and accurate to the best of my knowledge. I give permission for the Trust Committee to contact entities mentioned in this application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date