



COASTAL AUTHORITY CARE FOUNDATION

EMERGING THERAPY GRANT REQUEST



Coastal Authority Care Foundation, Inc. is a nonprofit corporation (EIN#: 81-0890793) organized and operated exclusively for charitable purposes, specifically to provide grants for evidence-based therapies that are not yet covered by insurance, such as hyperbaric oxygen therapy and neurofeedback to veterans with service-connected injuries, especially traumatic brain injury, PTS and chronic pain. These therapies help heal the wounds in the brain and body, improve symptoms and quality of life and help prevent suicide.

We are currently providing grants for hyperbaric oxygen therapy (HBOT) and neurofeedback/MeRT.

Additionally, we may also provide grants to veterans, their spouse or other accompanying family member to help pay for therapy-related travel and/or lodging expenses to the facility on a case by case basis.

Grant Request Criteria:

- The applicant must be a veteran of the United States Armed Forces who was injured as a result of military service, ie, injured during training, combat or while performing duties of his/her job.
- Transportation/Lodging grant request must be associated with treatment, if applicable.
- The therapy being requested must be from a licensed professional health care provider/practitioner.
- **Applicant:** Please submit the following along with the application:
 - a copy of DD214 (honorable discharge).
 - written evidence of diagnosis or injury (ie, diagnosis, medical records, doctor's report or doctor's letter describing diagnosis/condition that establishes that the injury is connected to military service).

How to apply?

- Please complete the **Grant Application** and email it along with relevant documentation listed above to jillcrist@cacarefoundation.org. In the subject line, please type **Grant Application**.
- If you prefer to use the US Postal Service, you may mail your application to **Coastal Authority Care Foundation, 1340 N Great Neck Road, Ste. 1272-362, Virginia Beach, VA 23454**. Please send an email to let us know you have mailed an application so that we may be on the lookout for it.
- Call Jill Crist 757-831-1612 with any questions.

Approval Process:

Please allow 5-7 business days for us to review the application.



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This information is strictly confidential and is only used for grant approval purposes. It will not be shared with anyone other than the treatment service provider so that they may give you the proper care.		
Applicant Name:	DATE OF BIRTH:	
Mailing Address:		
City:	State:	Zip Code:
Phone Number:	Email:	
Branch of Service:	Dates:	
Service-connected diagnosis or injury for which treatment is being requested:		
Did the injury occur as a result of you performing the duties of your job, ie, training, combat or other job-related accident? YES ____ NO ____		
Briefly describe the accident, incident(s) or trauma that caused the injury:		
What symptoms are you experiencing? ___Headaches, ___Dizziness, ___Trouble Sleeping, ___Depression ___Anxiety, ___Tinnitus, ___Anger Easily, ___Noise sensitivity, ___Chronic Fatigue, ___Memory issues ___Digestive Issues, ___Feeling hopeless, ___Poor Concentration, ___Slowed thinking, ___Blurred Vision ___Hypervigilance. Other: _____		
Date(s) of injury:		
What do you hope the requested therapy will do for you?		
Type of grant request: <input type="checkbox"/> Treatment <input type="checkbox"/> Transportation <input type="checkbox"/> Lodging		
Treatment Type:		
<input type="checkbox"/> Hyperbaric Oxygen Therapy <input type="checkbox"/> Neurofeedback/MeRT <input type="checkbox"/> FLYT Vibroacoustic & Light Therapy		
Treatment Facility: _____		
Contact Info (name, email, phone): _____		
Signature:_____ Date:_____		