Dear Friend,

Thank you for your interest in AFTD’s Comstock Quality of Life Grant. We are excited to offer this unique resource to people with an FTD disorder. The purpose of the Quality of Life Grants is to help persons with FTD to access needed services or support that they could not otherwise afford.

The changes that come with FTD make it harder to have a job, drive, do everyday tasks and enjoy time with friends and family. Paying for the resources you need to do your best can be difficult. AFTD’s Comstock Quality of Life Grants are intended to help persons with FTD defray the cost of goods or services that will improve their lives today. We offer some examples of how the grant may be used, but you decide what will help most based on your individual situation and needs. Care partners may help use the Quality of Life funds, as needed, but only on goods or services to benefit the person with FTD.

Persons with FTD may apply for one Comstock Quality of Life grant per AFTD fiscal year (July 1st – June 30th). Once approved, you will be given a pre-paid debit card for $500. Each debit card will have a tracking number that allows AFTD to see where the grant is used without you needing to worry about receipts or reimbursement.

After the grant money is used we will ask for your feedback to help us keep offering the grant to more people in the future. The Comstock Grant program is just one way that AFTD can assist you and your family to live as well as possible with FTD. Working together we will improve care and services for people with frontotemporal degeneration and their families, and drive research until there is a cure.

Sincerely,

Stephanie Quigley

Stephanie Quigley, MSW, LSW, CDP
HelpLine Manager
phone: 484-672-5686
e-mail: ComstockGrants@theaftd.org
COMSTOCK QUALITY OF LIFE GRANT GUIDELINES

GOALS
- Provide equipment, services, or supplies that could not otherwise be attained (daily or special).
- Supplement other sources of income, entitlement benefits and insurance for things otherwise not available.

EXAMPLES OF GRANT USES:
- Communication tools (Smart phone, iPad, writing board, computer software, apps, etc.)
- Broadband or internet costs (to maintain on-line support)
- Transportation including unreimbursed travel to participate in FTD research (taxi, accessible van, etc.)
- Companion care
- Insurance co-pays, medication costs, or therapies (occupational, physical, speech, or counseling services)
- Home adaptations
- Gym membership or exercise class
- Grooming and cosmetics (Haircuts, manicure/pedicure etc.)

ELIGIBILITY REQUIREMENTS
- Applicants must be diagnosed with an FTD disorder.
- Must be a resident of US.
- Provide copies of diagnostic report(s) showing how the diagnosis of FTD was made. The confidentiality of all personal information is protected. Medical records are destroyed after the initial grant is approved.

STIPULATIONS
- Applicant is responsible for all arrangements related to researching and securing the equipment, supplies or services of their choice.
- Applicant is responsible for using the debit card provided to pay for the equipment, supplies or services desired under the grant.
- Any expense above the $500 grant is the full responsibility of the applicant.
- All applicants must list a secondary contact that can assist the applicant with the application and/or use of the grant as needed.
- AFTD reserves the right to contact the secondary contact at any time in relation to the grant. Any blatant misuse of the grant funds awarded through the card, including use of the funds for the sole benefit of the primary care partner, will disqualify applicant from consideration for future Comstock Quality of Life grants.

GRANT RECIPIENTS ARE ASKED TO:
- Contact AFTD if you lose the debit card issued to you.
- Contact ACTD if you cannot use grant funds within six months of the approval date.
- Respond to AFTD requests for information about the grant program to help refine it for future applicants.

For questions or assistance in completing this application, please contact:

Stephanie Quigley, MSW, LSW, CDP
HelpLine Manager
phone: 484-672-5686
email: ComstockGrants@theaftd.org

Keep this page for your records.
**COMSTOCK QUALITY OF LIFE GRANT APPLICATION**

Fill out and return this page *with documentation of FTD diagnosis*:

<table>
<thead>
<tr>
<th>via mail:</th>
<th>via email:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFTD</td>
<td><a href="mailto:comstockgrants@theaftd.org">comstockgrants@theaftd.org</a></td>
</tr>
<tr>
<td>2700 Horizon Drive, Suite 120</td>
<td></td>
</tr>
<tr>
<td>King of Prussia, PA 19406</td>
<td></td>
</tr>
</tbody>
</table>

**APPLICANT INFORMATION (PERSON DIAGNOSED)**

Name: __________________________________________ Date of Birth: ______________

Address: _________________________________________________________________________________________

City: __________________________________________ State: _____________ Zip: ______________

Phone: ______________________________ Email: ______________________________________________________

Current living situation:
- [ ] At home with family  
- [ ] Alone in own home or apartment  
- [ ] With friends or someone else  
- [ ] In a group home, assisted living or nursing facility  

Have you been diagnosed with an FTD disorder?  
- [ ] Yes (Date:______________)  
- [ ] No

Subtype (if known):  
- [ ] bvFTD  
- [ ] PPA  
- [ ] CBD  
- [ ] PSP  
- [ ] FTD/ALS

Have you or your primary care partner ever received a Comstock Travel or Care partner Respite Grant from AFTD?  
- [ ] Yes (Year:_______)  
- [ ] No

How did you learn about the Comstock Quality of Life Grant? (Select all that apply)
- [ ] AFTD website  
- [ ] FTD support group  
- [ ] Friend or relative  
- [ ] AFTD staff  
- [ ] Other healthcare or community service provider

How do you anticipate using the Quality of Life Grant?

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________
Tell Us More About You and How We Can Help You

Please consider sharing this information, which can help AFTD to evaluate and expand the reach of our services.

Is the person living with FTD a U.S. veteran?
- [ ] Yes  [ ] No  [ ] I prefer not to disclose veteran status  [ ] I don't know

Ethnicity – How does the person living with FTD publicly self-identify?
- [ ] Hispanic/Latino/Latina/Latinx  [ ] Non-Hispanic/Latino/Latina/Latinx
- [ ] Multi Ethnic  [ ] Unknown  [ ] Decline to Say

Race – How does the person living with FTD publicly self-identify?
- [ ] Asian American/Pacific Islanders/Asian  [ ] Black/African American/African
- [ ] Native American/American Indian/Indigenous  [ ] White/Caucasian/European
- [ ] Multi Racial  [ ] Unknown  [ ] Decline to state

Gender Identity – How does the person living with FTD publicly self-identify?
- [ ] Female  [ ] Male  [ ] Non Binary  [ ] Decline to state  [ ] Other

SECONDARY CONTACT INFORMATION

Name: ___________________________________________ Date of Birth: ________________

Address: _________________________________________________________________________________________

City: ___________________________________________________ State: _____________ Zip: __________________

Phone: __________________________ Email: ______________________________________________________

Relationship to the person diagnosed:
- [ ] Spouse or partner  [ ] Adult child  [ ] Family (please specify) _________________________
- [ ] Friend  [ ] Representative of an agency or organization

REQUIRED SIGNATURE

I understand the above information to be correct as of ____________________.

[Today's Date]

Signature of Applicant: ___________________________________________________________________________

Signature of Secondary Contact: __________________________________________________________________