See a Social Security Number? Say Something!
Report Privacy Problems to https://public.resource.org/privacy
Or call the IRS Identity Theft Hotline at 1-800-908-4490

Short Form Return of Organization Exempt From Income Tax

Form **990-EZ**

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ Sponsoring organizations of donor advised funds and controlling organizations as defined in section 512(b)(13) must file Form 990. All other organizations with gross receipts less than $1,000,000 and total assets less than $2,500,000 at the end of the year may use this form

▶ *The organization may have to use a copy of this return to satisfy state reporting requirements*

OMB No 1545-1150

2008

Open to Public Inspection

A For the 2008 calendar year, or tax year beginning and ending

B Check if applicable:
- [X] Address change
- [ ] Name change
- [ ] Initial return
- [ ] Termination
- [ ] Amended return
- [ ] Application pending

Please use IRS label or print or type See Specific Instructions

C Name of organization

BUSBY FOUNDATION

Number and street (or P.O box, if mail is not delivered to street address) | Room/suite

3600 N CAP OF TX HWY, BLDG B, SUITE 250

City or town, state or country, and ZIP + 4

AUSTIN, TX 78746

D Employer identification number

20-2486640

E Telephone number

512-835-4455

F Group Exemption Number ▶

- **Section 501(c)(3) organizations and 4947(a)(1) nonexempt charitable trusts must attach a completed Schedule A (Form 990 or 990-EZ).**

G Accounting method [X] Cash [ ] Accrual Other (specify) ▶

I Website: ▶ WWW.BUSBYALS.COM

H Check ▶ [ ] if the organization is not required to attach Schedule B (Form 990, 990-EZ, or 990-PF)

J Organization type (check only one)— [X] 501(c) (3) ◀ (insert no) [ ] 4947(a)(1) or [ ] 527

K Check ▶ [ ] if the organization is not a section 509(a)(3) supporting organization **and** its gross receipts are normally **not** more than $25,000 A return is not required, but if the organization chooses to file a return, be sure to file a complete return

L Add lines 5b, 6b, and 7b, to line 9 to determine gross receipts; if $1,000,000 or more, file Form 990 instead of Form 990-EZ ▶ $ 569,995.

Part I Revenue, Expenses, and Changes in Net Assets or Fund Balances (See the instructions for Part I.)

Revenue	1	Contributions, gifts, grants, and similar amounts received			1 143,193.
	2	Program service revenue including government fees and contracts			2
	3	Membership dues and assessments			3
	4	Investment income			4 17,909.
	5a	Gross amount from sale of assets other than inventory STMT 2	5a 400,025.		
	b	Less cost or other basis and sales expenses	5b 400,196.		
	c	Gain or (loss) from sale of assets other than inventory (Subtract line 5b from line 5a) (attach schedule)			5c -171.
	6	Special events and activities (complete applicable parts of Schedule G) If any amount is from **gaming**, check here ▶ [ ]			
	a	Gross revenue (not including $ 19,700. of contributions reported on line 1)	6a 8,868.		
	b	Less direct expenses other than fundraising expenses	6b 8,374.		
	c	Net income or (loss) from special events and activities (Subtract line 6b from line 6a)			6c 494.
	7a	Gross sales of inventory, less returns and allowances	7a		
	b	Less. cost of goods sold	7b		
	c	Gross profit or (loss) from sales of inventory (Subtract line 7b from line 7a)			7c
	8	Other revenue (describe ▶)			8
	9	**Total revenue.** Add lines 1, 2, 3, 4, 5c, 6c, 7c, and 8 ▶			9 161,425.
Expenses	10	Grants and similar amounts paid (attach schedule)			10 13,659.
	11	Benefits paid to or for members			11
	12	Salaries, other compensation, and employee benefits			12
	13	Professional fees and other payments to independent contractors			13 30,665.
	14	Occupancy, rent, utilities, and maintenance			14
	15	Printing, publications, postage, and shipping			15
	16	Other expenses (describe ▶ SEE STATEMENT 1)			16 27,928.
	17	Total expenses (Add lines 10 through 16) ▶			17 72,252.
Net Assets	18	Excess or (deficit) for the year (Subtract line 17 from line 9)			18 89,173.
	19	Net assets or fund balances at beginning of year (from line 27, column (A)) (must agree with end-of-year figure reported on prior year's return)			19 431,983.
	20	Other changes in net assets or fund balances (attach explanation)			20
	21	Net assets or fund balances at end of year Combine lines 18 through 20 ▶			21 521,156.

Part II Balance Sheets. If Total assets on line 25, column (B) are $2,500,000 or more, file Form 990 instead of Form 990-EZ.

(See the instructions for Part II)		(A) Beginning of year		(B) End of year
22	Cash, savings, and investments	431,983.	22	521,156.
23	Land and buildings		23	
24	Other assets (describe ▶)		24	
25	**Total assets**	431,983.	25	521,156.
26	**Total liabilities** (describe ▶)	0.	26	0.
27	**Net assets or fund balances** (line 27 of column (B) must agree with line 21)	431,983.	27	521,156.

Part III Statement of Program Service Accomplishments (See the instructions for Part III.)

What is the organization's primary exempt purpose? SEE STATEMENT 5

Describe what was achieved in carrying out the organization's exempt purposes In a clear and concise manner, describe the services provided, the number of persons benefited, or other relevant information for each program title

Expenses (Required for 501(c)(3) and (4) organizations and 4947(a)(1) trusts, optional for others)

28 SEE STATEMENT 4

(Grants $) If this amount includes foreign grants, check here ▶ ☐ 28a 13,659.

29 DEDICATE FUNDS TO INDIVIDUALS CONDUCTING RESEARCH RELEVANT TO AMYOTROPHIC LATERAL SCLEROSIS

(Grants $) If this amount includes foreign grants, check here ▶ ☐ 29a

30 MAY MAKE GRANTS TO ORGANIZATIONS THAT SPONSOR AND/OR CONDUCT SCIENTIFIC RESEARCH RELEVANT TO AMYOTROPHIC LATERAL SCLEROSIS

(Grants $) If this amount includes foreign grants, check here ▶ ☐ 30a

31 Other program services (attach schedule)

(Grants $) If this amount includes foreign grants, check here ▶ ☐ 31a

32 **Total program service expenses** (add lines 28a through 31a) ▶ 32 13,659.

Part IV List of Officers, Directors, Trustees, and Key Employees. List each one even If not compensated (See the instructions for Part IV)

(a) Name and address	(b) Title and average hours per week devoted to position	(c) Compensation (If not paid, enter -0-.)	(d) Contributions to employee benefit plans & deferred compensation	(e) Expense account and other allowances
VOLNEY CAMPBELL, 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, TX	PRESIDENT, SECTY, DIRECTOR 1.00	0.	0.	0.
RICHARD ANDERSON, 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, TX	TREASURER, DIRECTOR 1.00	0.	0.	0.
HARRIS BASS, 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, TX 78746	DIRECTOR 0.00	0.	0.	0.
CHARLES COFFMAN, 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, TX	DIRECTOR 0.00	0.	0.	0.
SAM HOUSTON, 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, TX 78746	DIRECTOR 0.00	0.	0.	0.
GREG MARBERRY, 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, TX 78746	DIRECTOR 0.00	0.	0.	0.
JOHN GILLULY, 1221 S. MOPAC EXPRESSWAY, SUITE 100, AUSTIN, TX	DIRECTOR 0.00	0.	0.	0.

Part V Other Information (Note the statement requirements in the instructions for Part VI.)

			Yes	No
33	Did the organization engage in any activity not previously reported to the IRS? If "Yes," attach a detailed description of each activity	33		X
34	Were any changes made to the organizing or governing documents but not reported to the IRS? If "Yes," attach a conformed copy of the changes	34		X
35	If the organization had income from business activities, such as those reported on lines 2, 6a, and 7a (among others), but **not** reported on Form 990-T, attach a statement explaining your reason for not reporting the income on Form 990-T			
a	Did the organization have unrelated business gross income of $1,000 or more or section 6033(e) notice, reporting, and proxy tax requirements?	35a		X
b	If "Yes," has it filed a tax return on **Form 990-T** for this year?	35b	N/A	
36	Was there a liquidation, dissolution, termination, or substantial contraction during the year? If "Yes," complete applicable parts of Sch N	36		X
37a	Enter amount of political expenditures, direct or indirect, as described in the instructions ▶ 37a 0.			
b	Did the organization file **Form 1120-POL** for this year?	37b		X
38a	Did the organization borrow from, or make any loans to, any officer, director, trustee, or key employee **or** were any such loans made in a prior year and still unpaid at the start of the period covered by this return?	38a		X
b	If "Yes," complete Schedule L, Part II and enter the total amount involved 38b N/A			
39	Section 501(c)(7) organizations. Enter:			
a	Initiation fees and capital contributions included on line 9 39a N/A			
b	Gross receipts, included on line 9, for public use of club facilities 39b N/A			
40a	Section 501(c)(3) organizations Enter amount of tax imposed on the organization during the year under section 4911 ▶ 0. ; section 4912 ▶ 0. , section 4955 ▶ 0.			
b	Section 501(c)(3) and (4) organizations Did the organization engage in any section 4958 excess benefit transaction during the year or did it become aware of an excess benefit transaction from a prior year? If "Yes," complete Schedule L, Part I	40b		X
c	Enter amount of tax imposed on organization managers or disqualified persons during the year under sections 4912, 4955, and 4958 ▶ 0.			
d	Enter amount of tax on line 40c reimbursed by the organization ▶ 0.			
e	All organizations At any time during the tax year, was the organization a party to a prohibited tax shelter transaction? If "Yes," complete Form 8886-T	40e		X
41	List the states with which a copy of this return is filed ▶ TX			
42a	The books are in care of ▶ MARY JANE OROSCO Telephone no ▶ 512-835-4455			
	Located at ▶ 3600 N CAP OF TX HWY, BLDG B, SUITE 250, AUSTIN, ZIP + 4 ▶ 78746			
b	At any time during the calendar year, did the organization have an interest in or a signature or other authority over a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	42b		X
	If "Yes," enter the name of the foreign country ▶			
	See the instructions for exceptions and filing requirements for **Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.**			
c	At any time during the calendar year, did the organization maintain an office outside of the U S ?	42c		X
	If "Yes," enter the name of the foreign country ▶			
43	Section 4947(a)(1) nonexempt charitable trusts filing Form 990-EZ in lieu of **Form 1041** - Check here ▶ ☐ and enter the amount of tax-exempt interest received or accrued during the tax year ▶ 43 N/A			
44	Did the organization maintain any donor advised funds? If "Yes," Form 990 must be completed instead of Form 990-EZ	44		X
45	Is any related organization a controlled entity of the organization within the meaning of section 512(b)(13)? If "Yes," Form 990 must be completed instead of Form 990-EZ	45		X

Part VI **Section 501(c)(3) organizations only.** All section 501(c)(3) organizations must answer questions 46-49 and complete the tables for lines 50 and 51.

			Yes	No
46	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	46		X
47	Did the organization engage in lobbying activities? If "Yes," complete Schedule C, Part II	47		X
48	Is the organization operating a school as described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	48		X
49a	Did the organization make any transfers to an exempt non-charitable related organization?	49a		X
b	If "Yes," was the related organization(s) a section 527 organization?	49b		

50 Complete this table for the five highest compensated employees (other than officers, directors, trustees and key employees) who each received more than $100,000 of compensation from the organization If there is none, enter "None"

(a) Name and address of each employee paid more than $100,000	(b) Title and average hours per week devoted to position	(c) Compensation	(D) Contributions to employee benefit plans & deferred compensation	(E) Expense account and other allowances
NONE				
Total number of other employees paid over $100,000 ▶				

51 Complete this table for the five highest compensated independent contractors who each received more than $100,000 of compensation from the organization If there is none, enter "None"

NONE

(a) Name and address of each independent contractor paid more than $100,000	(b) Type of service	(c) Compensation
Total number of other independent contractors each receiving over $100,000 ▶		

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

▶ Signature of Officer — Date 8/16/10

▶ Type or print name and title

Paid Preparer's Use Only

Preparer's signature ▶		Date 3/10/10	Check if self-employed ▶ ☐	Preparer's Identifying Number (See instr) P00175041
Firm's name (or yours if self-employed), address, and ZIP + 4 ▶	POWELL, EBERT & SMOLIK, P.C. 515 CONGRESS, TWENTIETH FLOOR AUSTIN, TX 78701			EIN ▶ Phone no (512)320-8000

May the IRS discuss this return with the preparer shown above? See instructions ▶ [X] Yes ☐ No

Form **990-EZ** (2008)

832174
12-17-08

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

To be completed by all section 501(c)(3) organizations and section 4947(a)(1) nonexempt charitable trusts.

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No 1545-0047

2008

Open to Public Inspection

Name of the organization	Employer identification number
BUSBY FOUNDATION	20-2486640

Part I Reason for Public Charity Status (All organizations must complete this part.) (see instructions)

The organization is not a private foundation because it is: (Please check only **one** organization.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).** (Attach Schedule H.)

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☒ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete the Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).** (see instructions)

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I b ☐ Type II c ☐ Type III - Functionally integrated d ☐ Type III - Other

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?		
(ii)	A family member of a person described in (i) above?		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?		

h Provide the following information about the organizations the organization supports.

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document?		(v) Did you notify the organization in col (i) of your support?		(vi) Is the organization in col (i) organized in the U S ?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
Total									

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2004	(b) 2005	(c) 2006	(d) 2007	(e) 2008	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")		182,223.	159,759.	191,320.		533,302.
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 - 3		182,223.	159,759.	191,320.		533,302.
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						43,652.
6 **Public Support.** Subtract line 5 from line 4						489,650.

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2004	(b) 2005	(c) 2006	(d) 2007	(e) 2008	(f) Total
7 Amounts from line 4		182,223.	159,759.	191,320.		533,302.
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources		2,674.	11,627.	19,813.		34,114.
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						567,416.

12 Gross receipts from related activities, etc. (see instructions)	12	28,669.

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2008 (line 6, column (f) divided by line 11, column (f))	14	86.29 %
15 Public support percentage from 2007 Schedule A, Part IV-A, line 26f	15	80.02 %

16a **33 1/3% support test - 2008.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☒

b **33 1/3% support test - 2007.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2008.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2007.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2) (Complete only if you checked the box on line 9 of Part I)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2004	(b) 2005	(c) 2006	(d) 2007	(e) 2008	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 - 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of 1% of the total of lines 9, 10c, 11, and 12 for the year or $5,000						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2004	(b) 2005	(c) 2006	(d) 2007	(e) 2008	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support** (Add lines 9, 10c, 11, and 12)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2008 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2007 Schedule A, Part IV-A, line 27g	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2008** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2007** Schedule A, Part IV-A, line 27h	18	%

19a 33 1/3% support tests - 2008. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b 33 1/3% support tests - 2007. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

FORM 990-EZ OTHER EXPENSES STATEMENT 1

DESCRIPTION	AMOUNT
BANK CHARGES	225.
CREDIT CARD FEES	1,564.
MISCELLANEOUS EXPENSES	377.
WEBSITE	38.
PROGRAM EXPENSES	25,724.
TOTAL TO FORM 990-EZ, LINE 16	27,928.

FORM 990-EZ GAIN (LOSS) FROM PUBLICLY TRADED SECURITIES STATEMENT 2

DESCRIPTION	GROSS SALES PRICE	COST OR OTHER BASIS	EXPENSE OF SALE	NET GAIN OR (LOSS)
SALE OF UBS INVESTMENT	400,025.	400,196.	0.	-171.
TO FORM 990-EZ, LINE 5	400,025.	400,196.	0.	-171.

FORM 990-EZ INFORMATION REGARDING TRANSFERS ASSOCIATED WITH PERSONAL BENEFIT CONTRACTS STATEMENT 3

A) DID THE ORGANIZATION, DURING THE YEAR, RECEIVE ANY FUNDS, DIRECTLY OR INDIRECTLY, TO PAY PREMIUMS ON A PERSONAL BENEFIT CONTRACT? . . . . . [ ] YES [X] NO

B) DID THE ORGANIZATION, DURING THE YEAR, PAY PREMIUMS, DIRECTLY OR INDIRECTLY, ON A PERSONAL BENEFIT CONTRACT? . . [ ] YES [X] NO

Please see attached applications

PROVIDE FINANCIAL ASSISTANCE TO INDIVIDUALS LIVING IN THE GREATER AUSTIN

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
Sue Crow	**1/16/65**	ALSA ☐ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
13117 Fieldgate Dr., Austin, TX 75753		**512-251-2960**

Assistance Requested (please provide a detailed description of what is needed)

Walmart gift card for the holidays

Estimated Cost	Maximum Amount Approved

Diagnosis (please include the date of diagnosis and brief description of current symptoms)
Dx in spring 2004. Unable to move or speak and using hospice services at this time.

B. Primary Correspondent

Name	Relationship to applicant
Chuck Crow	Husband
Address	
Same	
Home Telephone (inc area code)	Alternate Telephone / Email address
	512-431-0021

C. Family Members

Name / Location	Relationship
Child	9
Name / Location	Relationship
Child	12
Name / Location	Relationship

D. Financial Information

Income Source: (Employment, SSDI, Etc)	Amount Received per Month:	Resources Exhausted:
		☐ Private Insurance
		☐ Medicare
		☐ DARS
		☐ Austin Barrier Removal
Total $		☐ ALSA Loan Closet

(Liability waiver)

Applicant / Representative Signature _____ Date _____

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
	1	1
	2	2

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted
Date Initials	Date Initials	Date Initials	Date Initials	Date Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

ALS Association Signature _____ **Date** _____

Busby Foundation Signature _____ **Date** _____

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
Shannon McGee	**9/10/63**	ALSA ☐ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
109 Woodley Rd., Leander, 78641	**vlmcgee@msn.com**	**512-745-0131**

Assistance Requested (please provide a detailed description of what is needed)

Walmart gift card for the holidays

Estimated Cost	Maximum Amount Approved

Diagnosis (please include the date of diagnosis and brief description of current symptoms)

Dx in fall of 2005 Using power wheelchair, slurred speech, needs assistance with most activities.

B. Primary Correspondent

Name	Relationship to applicant
Vickey McGee	Wife

Address
Same

Home Telephone (inc area code)	Alternate Telephone / Email address
	745-0131

C. Family Members

Name / Location	Relationship
Mattea, 7	Daughter
Name / Location	Relationship
Conagher, 5	Son
Name / Location	Relationship
Daughters age 22 and 24 / Out of house	

D. Financial Information

Income Source: (Employment, SSDI, Etc)	Amount Received per Month:	Resources Exhausted:
		☐ Private Insurance
		☐ Medicare
		☐ DARS
		☐ Austin Barrier Removal
Total $		☐ ALSA Loan Closet

(Liability waiver)

Applicant / Representative Signature _____ Date _____

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
	1	1
	2	2

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted
Date Initials	Date Initials	Date Initials	Date Initials	Date Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

ALS Association Signature _____ Date _____

Busby Foundation Signature _____ Date _____

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
Alex Vargas	**08/17/1973**	ALSA ☒ Busby Rep ☐ Committee ☐

Mailing address (Street and/or P O Box, City, State, ZIP Code)	Email Address	Phone Number
6011 Carnation Terrace Austin, TX	**Am25vargas@yahoo.com**	**512-494-5303**

Assistance Requested (please provide a detailed description of what is needed)

The family is also very low income and could use financial help during the holidays to be able to provide gifts for their three young children. A Walmart gift card would be a great help to them.

Estimated Cost

Diagnosis (please include the date of diagnosis and brief description of current symptoms)

Alex was diagnosed with ALS in June 2003. Uses power wheelchair and has slurred speech.

B. Primary Correspondent

Name	Relationship to applicant
Ramona Vargas	**Wife**

Address (include City, State, and ZIP Code)
Same as above

Home Telephone (inc area code)	Alternate Telephone / Email address
512-494-5303	

C. Family Members

Name	Relationship	Age
Manual	**Son**	**14**
Trinidad	**Son**	**13**
Zoe	**Daughter**	**6**

D. Financial Information

Income Source (Employment, SSDI, Etc)	Monthly Amount	Resources Exhausted:
		☒ Private Insurance
		☒ Medicare
		☒ DARS
		☒ Austin Barrier Removal
Annual Total		☒ ALSA Loan Closet

Applicant / Representative Signature **Date**

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
	1	1
	2	2

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted

Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials
* Please attach any relevant bids, specifications, invoices, evaluations, etc									

D. Other Information

Please provide any other relevant information for review

ALS Association Signature _____ Date _____

Busby Foundation Signature _____ Date _____

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
Sandra Brown	**02/01/1974**	ALSA ☒ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
3002 Flower Hill, Round Rock - Mailing: Po Box 80562 Austin, TX 78708	**l4hbrown@yahoo.com**	**512-803-6633**

Assistance Requested (please provide a detailed description of what is needed)

Sandra Brown (ALS Patient) currently lives with her sister Crystal and Crystal's 4 children. Sandra applied for Medicaid on 1/1/08 in Williamson County. Once approved for Medicaid (hopefully in 3-4 weeks), Sandra will receive caregiving services through the Department of Aging and Disability Services. In the meantime, the family cannot afford to pay for a caregiver to come into the home. Sandra is home alone during the day while Crystal is at work, 4 days per week, approximately 10am-5pm. Crystal reports that the greatest need for them right now is to have someone there for at least a few hours while she is gone. Home Instead Senior Care has agreed to provide services at a rate of $18 per hour, 4 hours per day, 4 days per week.
$18 x 4 hrs x 4 days = $288 / wk (4 weeks = $1152)

Estimated Cost	Maximum Amount Approved
$1200	

Diagnosis (please include the date of diagnosis and brief description of current symptoms)

Sandra Brown is a 33 year old single female who was diagnosed with ALS in July 2007. To date she has lost the ability to move and care for herself and must have assistance with all activities of daily living. Thus far, she has maintained the ability to eat by mouth and speak, though these areas have also begun to decline. Her sister and 2 older nieces currently provide all of her care. Sandra may be suffering from FTD – a mild cognitive impairment sometimes associated with ALS – which only exacerbates her situation.

B. Primary Correspondent

Name	Relationship to applicant
Crystal Brown	**Sister of Patient**

Address
Po Box 80562 Austin, TX 78708

Home Telephone (inc area code)	Alternate Telephone / Email address
512 -803-6633	**l4hbrown@yahoo.com**

C. Family Members

Name / Location	Relationship
Braylan & Breshae – 17 months (twins)	**Niece / Nephew**
Alexis – 11 Years	**Niece**
Aubrey – 12 Years	**Niece**

D. Financial Information

Income Source: (Employment, SSDI, Etc)	**Amount Received per Month:**	**Resources Exhausted:**
Crystal's Paycheck (USPS)	$1700 00	☒ **Private Insurance**
		☒ **Medicare**
		☒ **DARS**
		☒ **Austin Barrier Removal**
Total $ 1,700 00 / Month - $20,400 / year		☒ **ALSA Loan Closet**

(Liability waiver)

_____ _____

Applicant / Representative Signature **Date**

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
	1	1
	2	2

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted
Date Initials	Date Initials	Date Initials	Date Initials	Date Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

Melina Monson — **2/5/08**

ALS Association Signature — Date

Busby Foundation Signature — Date

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name: Paul B Bailey	Date of Birth: 12/04/1951	Approve: ALSA [X] Buddy Pop [ ] Committee [ ]
Mailing address: [illegible] Cedar Park Tx [illegible]	Email Address: [illegible]	Phone Number: 512-[illegible]

Assistance Requested (please provide a detailed description of what is needed):

By the 1 of April I will be 3 months behind in my house payment. I called the Social Security Office last Jan and they set me up an appointment for the [illegible] of Jan. I was told at the time because both of my legs are [illegible] due to the progression of ALS I could qualify for [illegible]. Ms. [illegible] at Social Security told me that I can qualify for 1978.00 per month and pay Medicare 96.00 per month. She went on to explain to me that you cannot make more than [illegible] per month. She said the waiting period was for [illegible] days. I went back to Extra Personnel and they told me the best they could do was to send me over to the [illegible] and fill out [illegible]. I did that however I have not been called on one single [illegible]. I am going to a job fair in Cedar Park on Sat the 23rd of Feb to apply for a Toll Booth Operator. I have not received [illegible]. My wife works for Nannies of the Heart and she has been working making [illegible] a week. [illegible] I bought it in [illegible]. In [illegible] refinanced the house [illegible]. I have just [illegible] the mortgage. I [illegible] a Social Security Ombudsman and was [illegible]. The [illegible] said that I was approved for benefits however I would have to wait 5 months with a continued disability. I have written [illegible] Congress. When I receive my disability I will be able to meet our financial obligation. I will [illegible] for your assistance.

Estimated Cost: [illegible]	Maximum Amount Approved:

Diagnosis (please include the date of diagnosis and brief description of current symptoms):

On Dec [illegible] 2007 Dr Hand told me I had ALS. At that time my left foot did not operate. He orders a Brace for my left leg. He told me I could go to Houston, Dallas or San Antonio because Austin was not yet an approved ALS branch. I told him I would [illegible] San Antonio [illegible] he [illegible]. I was scheduled for my on the 15 th. of Jan and came to be examined by Dr Jackson. She did her tests and had me return to San Antonio on the 22nd of for more tests. She confirmed with Dr Hand that I did have ALS. She orders a brace for my right leg and also a walker. From the EMG I was told I had activity in all areas he tested me.
I have issues balancing and both my hands and arms have cramps.

B. Primary Correspondent

Name: [illegible]	Relationship to applicant: [illegible]
Address: [illegible]	
Home Telephone (w/ area code):	Alternate phone/email address:

C. Family Members

Name / location: Nicole Winchor Austin Tx	Relationship: Daughter
Name / location: Crystal Bailey Austin Tx	Relationship: Grandson
Name / location: Erik Bailey Portland Ore	Relationship: Son

D. Financial Information

Income Source (employment, SSDI, etc.)	Amount Received per Month
Nannies of the Heart	1600
Total: $ [illegible]	

Resources Exhausted:

- [X] Private Insurance Plan Exhausted
- [ ] Medicare Should have by April [illegible]
- [X] [illegible]
- [X] Austin Easter Seals
- [X] ALS [illegible] Closet

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
Sue Grabarkewitz	02/07/45	ALSA ☐ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
62 5 S Guadalupe St Lockhart Tx 78644	Debbiesalinas1@hotmail.com	376-9371

Assistance Requested (please provide a detailed description of what is needed)

I need to install a summit lift in my home for my mother to be able to transfer from the living space to the rest of the house. I already have a ramp being installed as well as additional changes being made to the bathroom for her My house is multi level and this is the best solution for her to be able to function in the house. We will have a wheelchair up stairs and one down stairs for her which we already have My Mother has fallen three times in the last two days and my Father can no longer help her up. We decided in the beginning that my parents would live with me and I would take care of her. Living with me will allow me the opportunity to be her number one caregiver and allow me to keep my children in their home I have plenty of room and have made additional modifications to my home for her to be comfortable. The cost to have the lift installed is $500.00. We also need an extension for the railing. It is not long enough for our house.

(ALSA – This family borrowed a short track lift from the ALSA loan bank and need to have it extended and installed to meet their needs.)

Estimated Cost $800.00 **Maximum Amount Approved**

Diagnosis (please include the date of diagnosis and brief description of current symptoms):

My Mother was diagnosed in January of 2008 Her feet have become more dropped to where without her braces, she can not walk With her braces she has fallen 3 times in the last 2 days. She is depressed and I have had to have her medication increased to 75 mg Her speech is somewhat slurred, especially when she is tired She is having trouble writing

B. Primary Correspondent

Name	Relationship to applicant
Debbie Sal inas	Daughter
Address	
16212 Monks moun tain	
Home Telephone (inc area code)	**Alternate Telephone / Email address**
266 -0569	cell 554 -2240

C. Family Members

Name / Location	Relationship
Sam Grabarke witz	Husband
Name / Location	
Pati Hiltsley / Ari zona	sister
Name / Location	Relationship
Sharon Hebb / Conneticu t	Sister

D. Financial Information

Income Source: (Employment, SSDI, Etc)	Amount Received per Month:	Resources Exhausted:
Re tired	900 00	☒ Private Insurance
		☒ Medicare
		☐ DARS
		☐ Austin Barrier Removal
Total $ 900 00		☒ ALSA Loan Closet

(Liability waiver)

Applicant / Representative Signature _____ Date _____

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
AllStar Lifts	1 Linda	1 636-5806
	2	2

Specifications / Evaluation Complete		Item / Service Ordered		Item / Service Delivered		Project Complete		Family Contacted	
Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

ALS Association Signature _____ Date _____

Busby Foundation Signature _____ Date _____

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
Randall "Scott" Brown	**6/28/64**	ALSA ☒ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
245 Linam Ln., Cedar Creek, TX 78612	**Farmerbrown4@hotmail.com**	**512-590-2858**

Assistance Requested (please provide a detailed description of what is needed)

Master bedroom and bathroom modifications, area to small for a wheel chair. Would like to extend area by 10 more feet if possible.

Ramps needed for transporting scooter. Right now we take the manual wheel chair wherever we go.

Note: This family completed construction on their home and moved in just days prior to his ALS diagnosis. There is one full bath and one half-bath on the first floor, but neither one is wheelchair accessible.

Estimated Cost	Maximum Amount Approved

Diagnosis (please include the date of diagnosis and brief description of current symptoms)
Diagnosis March 2008. Current symptoms: Slurred speech, some choking, unbalanced (legs are weak and has fallen several times) using leg braces to help stay somewhat balanced, needs assistance in setting up when laying down, unable to perform hygiene tasks, difficulty in feeding himself.

B. Primary Correspondent

Name	Relationship to applicant
Kim Brown	Wife
Address	
Same as above	
Home Telephone (inc area code)	**Alternate Telephone / Email address**
512-590-2858	

C. Family Members

Name / Location	Relationship
Jamie, 14, at home	Daughter
Name / Location	Relationship
Jessica, 18, at home	Daughter
Name / Location	Relationship

D. Financial Information

Income Source: (Employment, SSDI, Etc)	**Amount Received per Month:**	**Resources Exhausted:**
SSDI – Scott, Jessica, Jamie	2100 00	☒ **Private Insurance**
Employment	2200 00	☐ **Medicare**
IBEW Annuity Fund	500.00	☐ **DARS**
		☐ **Austin Barrier Removal**
Total $ 4800 00		☐ **ALSA Loan Closet**

(Liability waiver)

Melina Monson, BSW

_____ ____3-20-08____

Applicant / Representative Signature **Date**

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
	1	1
	2	2

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted
Date Initials	Date Initials	Date Initials	Date Initials	Date Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

ALS Association Signature _____ Date _____

Busby Foundation Signature _____ Date _____

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name		Approval?
ROBERT P. NUNIS	1/18/2008	ALSA ☐ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
1009 CAVALRY RIDE TRAIL, AUSTIN, TX. 78732	gahou@aol.com	512/266-6078

Assistance Requested (please provide a detailed description of what is needed)

Need to rent a power chair for cruise which is a gift from our son. We do not have a van to take the one we have at home. See attached

Estimated Cost $296.00	Maximum Amount Approved

Diagnosis (please include the date of diagnosis and brief description of current symptoms)

ALS – DIAGNOSED 2 YEARS AGO THIS PAST SEPTEMBER,. 2008

B. Primary Correspondent

Name	Relationship to applicant
GEORGIA NUNIS	WIFE
Address: 1009 CAVALRY RIDE TRAIL, AUSTIN, TX. 78732	
Home Telephone (inc area code): 512/266-6078	Alternate Telephone / Email address: 512/266-5745

C. Family Members

Name / Location	Relationship
ROY NUNIS	BRO
4117 PAINT ROCK, AUSTIN, TX 78731	Relationship
Name / Location	Relationship

D. Financial Information

Income Source: (Employment, SSDI Etc)	Amount Received per Month:	Resources Exhausted:
SOCIAL SECURITY	$1,288 20	☐ Private Insurance
		☐ Medicare
		☐ DARS
		☐ Austin Barrier Removal
Total $ 1,288 20		☐ ALSA Loan Closet

(Liability waiver)

Applicant / Representative Signature _____ Date _____

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email

	1	1
	2.	2

Specifications / Evaluation Complete	Item / Service Ordered	Item / Service Delivered	Project Complete	Family Contacted
Date Initials	Date Initials	Date Initials	Date Initials	Date Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

ALS Association Signature _____ **Date** _____

Busby Foundation Signature _____ **Date** _____

ALS Association
South Texas Chapter

June 2007

Assistance Application

A. Applicant Information

Name	Date of Birth	Approval?
GERRY GARGES	10/31/1956	ALSA ☐ Busby Rep ☐ Committee ☐

Mailing address	Email Address	Phone Number
12201 JILL SUE COURT AUSTIN, TX 78750	ggarges@sbcglobal.net	512 947-5381

Assistance Requested (please provide a detailed description of what is needed)

Extend back of house to allow for construction of
1. ADA bathroom with roll-in shower
2. Create a larger living area for room to maneuver with wheelchair
3. Enlarge & remodel kitchen to make it more accessible to someone in a wheelchair

Due to the current floor plan of my house it is not possible to remodel either bathroom for ADA use since neither can be enlarged to allow for modifications including enlarging doors or shower area.
With an expansion we will also be able to reconfigure rear door of house and allow me access to the back patio & backyard, currently I can only enter or exit the house thru the front door.
I have just been approved for SS Disability and Medicare, and had to purchase a minivan with a VMI conversion

Estimated Cost $50,000.00	Maximum Amount Approved

Diagnosis (please include the date of diagnosis and brief description of current symptoms)

ALS, Official diagnosis October 2007
Currently no longer ambulatory, some loss of dexterity in my hands and fingers, use a Bi-Pap for sleeping since July 2008
No longer driving since August 2008
My wife Claudia still works and is my primary care taker
Current Ins thru Scott & White
Had been self employed contractor for last 12 years, Business still operating, but on a smaller scale since I am unable to work or even get on most jobsites, Business has been barely self sustaining for several years coinciding with the onset of my symptoms starting with neuropathy in my right leg almost 6 years ago

B. Primary Correspondent

Name	Relationship to applicant
Gerry Garges	Self
Address: 12201 Jill Sue Court	
Home Telephone (inc area code): 512 258-5380	Alternate Telephone / Email address: 512 947-5381 / ggarges@sbcglobal.net

C. Family Members

Name / Location	Relationship
Claudia Garges	Wife
Jeremy Bednarz Allen, Tx	Relationship: Step- son
Name / Location	Relationship

D. Financial Information

Income Source: (Employment, SSDI, Etc)	Amount Received per Month:	Resources Exhausted:
Gerry Garges Construction	1,500 00	X ☐ Private Insurance
Dillards	1,200 00	☐ Medicare
		☐ DARS
		☐ Austin Barrier Removal
Total $ 2,700 00		☐ ALSA Loan Closet

(Liability waiver)

Applicant / Representative Signature _____ Date _____

E. Project Information

Contractor / Agency / Individual Providing Service	Contact Name	Phone/Email
GGCC	1. Gerry Garges	1. 512 947-5381
	2	2.

Specifications / Evaluation Complete		Item / Service Ordered		Item / Service Delivered		Project Complete		Family Contacted	
Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials

* Please attach any relevant bids, specifications, invoices, evaluations, etc

D. Other Information

Please provide any other relevant information and/or photos

I a m currently working on blueprints for the necessary work and specifications to complete the job

ALS Association Signature _____ Date _____

Busby Foundation Signature _____ Date _____