



A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies
Application Form - Part B – Page 1

APPLICANT'S / CHILD'S GENERAL INFORMATION

LAST NAME: _____ FIRST NAME: _____
CURRENT AGE: _____ DATE OF BIRTH: _____ GENDER: M _____ F _____
STREET ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP CODE: _____
SOCIAL SECURITY #: _____ DATE OF APPLICATION: _____

PARENT / GUARDIAN'S GENERAL INFORMATION

GUARDIAN # 1- SPECIFY RELATIONSHIP TO CHILD: _____

LAST NAME: _____ FIRST NAME: _____
MARITAL STATUS: _____ SOCIAL SECURITY: _____
STREET ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMPLOYER'S / NAME / ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME TEL: _____ CELLULAR TEL: _____
WORK TEL: _____ E-MAIL: _____

GUARDIAN # 2- SPECIFY RELATIONSHIP TO CHILD: _____

LAST NAME: _____ FIRST NAME: _____
MARITAL STATUS: _____ SOCIAL SECURITY: _____
STREET ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMPLOYER'S / NAME / ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME TEL: _____ CELLULAR TEL: _____
WORK TEL: _____ E-MAIL: _____



A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies
Application Form - Part B – Page 2

OTHER DEPENDANT'S INFORMATION(NOT APPLICANT)

NAME # 1: _____ RELATION TO APPLICANT/CHILD: _____

AGE: _____ ANY SIMILAR DIAGNOSIS/DISABILITY: _____

NAME # 2: _____ RELATION TO APPLICANT/CHILD: _____

AGE: _____ ANY SIMILAR DIAGNOSIS/DISABILITY: _____

NAME # 3: _____ RELATION TO APPLICANT/CHILD: _____

AGE: _____ ANY SIMILAR DIAGNOSIS/DISABILITY: _____

SCHOOL ATTENDED BY APPLICANT

NAME: _____ ADDRESS: _____

TEL: _____ TEACHER'S NAME: _____ GRADE: _____

FAMILY SITUATION / BRIEF DESCRIPTION

FAMILY INCOME INFORMATION

GUARDIAN # 1 GROSS YEARLY INCOME: _____

GUARDIAN # 2 GROSS YEARLY INCOME: _____

OTHER SOURCE AND AMOUNT OF YEARLY INCOME: _____



A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies
Application Form - Part B – Page 3

APPLICANT'S / CHILD'S HEALTH INSURANCE COVERAGE

INSURANCE NAME: _____

INSURANCE ADDRESS: _____

CONTACT PERSON: _____ TEL: _____

I.D NUMBER: _____ GROUP NUMBER: _____

PRIMARY INSURED: _____ RELATIONSHIP: _____

APPLICANT'S / CHILD'S MEDICAL INFORMATION

CURRENT DIAGNOSIS: _____

DATE OF DIAGNOSIS: _____

DIAGNOSED BY(PHYSICIAN'SNAME): _____

SPECIALTY: _____ TEL: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ TEL: _____

ARE THERE OTHER PHYSICIANS INVOLVED IN CHILD'S TREATMENT ? Y ___ N ___

NAME: _____ SPECIALTY: _____ TEL: _____

NAME: _____ SPECIALTY: _____ TEL: _____

NAME: _____ SPECIALTY: _____ TEL: _____

NAME: _____ SPECIALTY: _____ TEL: _____

HAS YOUR CHILD RECEIVED THERAPY IN THE PAST ? Y ___ N ___

PHYSICAL: _____ HRS WEEKLY: _____ PROVIDER'S NAME: _____

ADDRESS AND TEL: _____

OCCUPATIONAL: _____ HRS WEEKLY: _____ PROVIDER'S NAME: _____

ADDRESS AND TEL: _____

SPEECH: _____ HRS WEEKLY: _____ PROVIDER'S NAME: _____

ADDRESS AND TEL: _____



A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies
Application Form - Part B – Page 4

IS YOUR CHILD CURRENTLY RECEIVING THERAPY ? Y____N____

PHYSICAL: _____ HRS WEEKLY: _____ PROVIDER'S NAME: _____

ADDRESS AND TEL: _____

OCCUPATIONAL: _____ HRS WEEKLY: _____ PROVIDER'S NAME: _____

ADDRESS AND TEL: _____

SPEECH: _____ HRS WEEKLY: _____ PROVIDER'S NAME: _____

ADDRESS AND TEL: _____

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

THIS AUTHORIZES THE USE AND/OR RELEASE OF THE PROTECTED HEALTH INFORMATION AS NOTED ABOVE FOR PURPOSES OF THE GRANT REVIEW PROCESS BY ACT4ME, INC. I _____

RELATIONSHIP TO APPLICANT: _____ (PRINT NAME)

GIVE PERMISSION TO ACT4ME, INC., ITS BOARD OF DIRECTORS AND/OR GRANT REVIEW COMMITTEE, TO VERIFY ALL MEDICAL HISTORY, INSURANCE COVERAGE AND TREATMENT INFORMATION, BY CONTACTING THE PROVIDERS DIRECTLY. I RESERVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING TO ACT4ME, INC., AT ANY TIME, USING CERTIFIED MAIL WITH RETURN RECEIPT. THIS WILL ALSO CANCEL THE GRANT REVIEW PROCESS, APPLICATION & AWARD.

DATE: _____ GUARDIAN # 1- SIGNATURE: _____

DATE: _____ GUARDIAN # 2- SIGNATURE: _____



A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies
Application form - Part B – Page 5

FUNDS REQUEST FOR GRANT

FUNDS MAY BE REQUESTED FOR DIRECT TREATMENT WITH THE CHILD'S THERAPY PROVIDER FOR A ONE TIME GRANT AMOUNT NOT TO EXCEED \$ 3,500.00 OR FOR HOME THERAPY SUPPLIES NOT TO EXCEED THE SAME VALUE AMOUNT.

MY GRANT REQUEST APPLIES TO

DIRECT TREATMENT: YES ___ NO ___ PROVIDER NAME: _____

PROVIDER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PROVIDER CONTACT TEL. NUMBER: _____

CURRENT COST PER TREATMENT: _____

CURRENT DURATION OF EACH TREATMENT (1/2 HR – HR): _____

CURRENT FREQUENCY OF EACH TREATMENT (TIMES/WEEK): _____

OR HOME THERAPY SUPPLIES: YES ___ NO ___

PLEASE LIST BELOW YOUR WISH LIST FOR HOME THERAPY SUPPLIES NEEDED

1 DESCRIPTION: _____ USED: _____ NEW: _____

VENDOR: _____ TEL: _____ COST: _____

2 DESCRIPTION: _____ USED: _____ NEW: _____

VENDOR: _____ TEL: _____ COST: _____

3 DESCRIPTION: _____ USED: _____ NEW: _____

VENDOR: _____ TEL: _____ COST: _____

4 DESCRIPTION: _____ USED: _____ NEW: _____

YOU MAY USE AND ATTACH A SEPARATE SHEET IF REQUIRED



A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies
Application Form - Part B – Page 6

SIGNATURES AND GRANT REQUEST REVIEW

ARE YOU CURRENTLY REQUESTING A GRANT(S) FROM ANOTHER ORGANIZATION ?

YES ___ NO ___ IF YES EXPLAIN: _____

HAVE YOU EVER REQUESTED A GRANT FROM ACT4ME, INC. ?

YES ___ NO ___ IF YES EXPLAIN: _____

I _____ CERTIFY THAT ALL INFORMATION INCLUDED IN THIS APPLICATION IS TRUE AND VERIFIABLE.

SIGNATURE OF PARENT/GUARDIAN# 1

DATE

SIGNATURE OF PARENT/GUARDIAN# 2

DATE

FOR ACT4ME BOARD REVIEW USE ONLY

APPLICATION RECEIVED DATE: _____ REVIEWED BY: _____

INCOME VERIFICATION YES ___ NO ___ TAX RETURNS INCLUDED YES ___ NO ___

DIAGNOSIS VERIFICATION YES ___ NO ___ TREATMENT VERIFICATION YES ___ NO ___

INSURANCE VERIFICATION YES ___ NO ___ PROVIDER LETTERS INCLUDED YES ___ NO ___

APPROVED _____ GRANT AMOUNT \$ _____ HOME THERAPY SUPPLIES AMOUNT \$ _____

DECLINED/REASON _____

APPLICANT NOTIFIED ON _____ BYPHONE _____ BYMAIL _____

BOARD APPROVAL SIGNATURE – DATE NOTES _____

