Application Packet

2017 Grant Schedule:
Applications Due May 4, 2017
Grants Awarded May 19, 2017

Applications Due October 19, 2017
Grants Awarded November 3, 2017

The Application for Funds must be complete and submitted by the due date in order to be considered.

Please send completed applications to:

Elevations
325 S. University Rd. Suite 203
Spokane Valley, WA 99206
Fax: 509-921-9774

Please contact us with questions at 509-385-2116

Thank you for your interest in Elevations!

Elevations: A Children's Therapy Resource Foundation
Application for Funds

Privacy and Terms of Use: Elevations respects your rights of privacy. The information received by Elevations will be used solely to determine eligibility for grant funds and will never be sold. By completing and submitting this application, you give permission to contact you, your child's providers, your insurance company, or other relevant entities indicated on this application for additional information or clarification specific to determining eligibility for grant funds. Elevations compiles demographic information for the sole purpose of gathering statistics about the need for services in our community.

*Please send your completed application to:
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325 S University Rd Suite 203
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Fax: 509-921-9774

*Please call us with questions: **509-385-2116**

PART 1: To be completed by a parent or legal guardian

Child's Name: _____Date of Birth: _____ Age: ___

Parent(s)/Legal Guardian(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number(s): _____ _____

Email address: _____

REQUIRED: Applicant's Specific Request to Elevations for Funding (number of visits, number of copays and amount, specific equipment, other request):

_____ **AND** Total Amount Requested: $_____

Child's Medical Information:

Child's Diagnosis: _____

Primary Care Provider(s): _____

Child's School and Therapy Information:

Name of School: _____ District: _____ Grade: _____

Is your child receiving therapy services provided by the school district? **Yes___No___**

If yes, ____ PT: minutes per week: _____ Therapist: _____

____ OT: minutes per week: _____ Therapist: _____

____ Speech: minutes per week: ____Therapist: _____

____ Other: minutes per week: ____ Therapist: _____

If no, why not? _____

Outpatient Therapy Service Provider (primary): _____

____ PT: minutes per week: _____ Therapist: _____

____ OT: minutes per week: _____ Therapist: _____

____ Speech: minutes per week: ____Therapist: _____

____ Other: minutes per week: ____ Therapist: _____

Additional Outpatient Therapy Service Provider(s): _____

____ PT: minutes per week: _____ Therapist: _____

____ OT: minutes per week: _____ Therapist: _____

____ Speech: minutes per week: ____Therapist: _____

____ Other: minutes per week: ____ Therapist: _____

REQUIRED: Signature of parent/guardian

_____ _____

Parent/Legal Guardian signature Date

PART 2: To be completed by a parent or legal guardian

Are you aware of other funding opportunities for your child? **Yes___ No___**

If yes, what are your resources? _____

Have you received other funding for child's therapy or equipment needs? **Yes___ No___**

If yes, who provided funds? _____

REQUIRED: Your Child's Story: Please provide us with some information about your child. The information can include, but is not limited to, how the funding you requested will:

1. Improve your child's daily life?
2. Change the long-term outlook for your child?
3. Affect your family's quality of life?

Also consider providing information about your child's personality traits, prognosis in therapy, treatment history, and treatment goals.

Please tell us why this funding is important to everyone involved in your child's care. If you are requesting funding for equipment, please tell us if your child has tried the equipment and what you observed.

** You may use this space or attach additional pages as necessary.

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PART 3: To be completed by the Therapy Provider referring the family/child to Elevations

Provider Name: _____

Clinic/Place of Employment: _____Phone: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Relationship to Applicant: _____

REQUIRED: Funding Request:
The following is a list of approved uses of the funds requested, however you may apply for reasons not listed. Please indicate your requests below as specifically as possible. For therapy services, indicate number of visits requested or dollar amount.

___ PT: ____ visits OR amount to fund services _____

___ OT: ____ visits OR amount to fund services _____

___ Speech: ____ visits OR amount to fund services _____

___ Mental Health: ____ visits OR amount to fund services _____

___ Behavioral Therapy: ____ visits OR amount to fund services _____

___ Dietician/Nutritional Services: ____ visits OR amount to fund services _____

___ Hippotherapy: ____ visits OR amount to fund services _____

___ Equipment: _____ (provide photo and order form)

Cost of equipment requested: _____

___ Other: (specify) _____ cost: _____

TOTAL AMOUNT REQUESTED: $_____

Additional provider name(s) and contact information if different from above:
_____
_____

PART 3 (continued): To be completed by the Therapy Provider referring the family/child to Elevations

Child's Insurance Information:

Insurance Carrier: _____

Does this insurance carrier provide coverage for therapy services? **Yes___ No___**

Visits allowed per year: _____ Copay per visit: _____

Visits recommended by Provider per year: _____

Annual deductible: _____ Annual Out of Pocket Expense: _____

Does this insurance carrier provide coverage for equipment? **Yes___ No___**

If requesting equipment, has child used the equipment in a clinic setting? **Yes___ No___**

Comments: _____

Please provide any additional information and/or justification for this funding request (ex: insurance benefits limit or do not cover services, child's progress in therapy or with specific equipment):

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_____

REQUIRED: Provider Signature

_____ _____

Provider Signature Date