Application Packet

2018 Grant Schedule:
Applications Due May 2, 2018
Grants Awarded May 18, 2018

Applications Due October 24, 2018
Grants Awarded November 9, 2018

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 202
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. We will not share your personal information with anyone other than a representative of Elevations. We may contact you or your child's providers indicated on this application for additional information or clarification specific to determining eligibility for grant funds. If you are awarded grant funds, a photo may be requested for promotional purposes.

*Please send your completed application to:
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325 S University Rd Suite 202
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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 Name: ________________________________

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 your child's therapy or equipment needs? **Yes / No**

If yes, who provided funds? ______________________________________

What was funded? ____

When were funds used? __________

*****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.

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

Provider Name: ____

Clinic/Place of Employment: _____________________________Phone: ___________

I provide services in Spokane, WA **yes / no**

I am licensed in Washington as a/an ____.

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. <u>Please indicate your requests below as specifically as possible</u>. 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 ___________

___ Music Therapy: ____ 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 <u>Therapy Provider</u> 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 the child used the equipment in the 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):

*****REQUIRED: Provider Signature*****

___________________________________ __________________

Provider Signature Date