Application Packet

2019 Grant Schedule:
Applications Due April 17, 2019
Grants Awarded May 3, 2019

Applications Due October 16, 2019
Grants Awarded November 1, 2019

The Application for Funds must be complete and submitted by the due date in order to be considered. Grant funds are for dates of service following the grant award and cannot be used for past services/balances.

Please send completed applications to:

Elevations
325 S. University Rd. Suite 203
Spokane Valley, WA 99206
Fax: 509-558-8464

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 specific to determining eligibility for grant funds. If you are awarded grant funds, you agree to answer a brief survey six months after the award.

Please send your completed application to:
Elevations
325 S University Rd Suite 203
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Fax: 509-558-8464

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: Signature of parent/guardian

_____ _____
Parent/Legal Guardian signature Date

Child's Medical Information:

Child's Diagnosis: _____

Primary Care Provider(s): _____

Child's School and Therapy Information:

Name of School: _____ District: _____ Grade: _____

My child receives therapy services provided by the school district: **Yes____No____**

If yes, My child receives: ____ minutes per week of PT, ___ minutes per week of OT,

____ minutes per week of Speech, and/or ____ minutes per week of _____

If no, why not? _____

Outpatient Therapy Services:

____ minutes per week of PT Therapist: _____ Clinic: _____

____ minutes per week of OT Therapist: _____ Clinic: _____

____ minutes per week of Speech Therapist: _____ Clinic: _____

____ minutes per week of _____ Therapist: _____ Clinic: _____

____ minutes per week of _____ Therapist: _____ Clinic: _____

____ minutes per week of _____ Therapist: _____ Clinic: _____

Comments: _____

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? _____

What was funded? _____

When were funds used? _____

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

I have discussed this request for funding with my child's therapist/provider: **Y___N___**

_____ **AND** Total Amount: $_____

REQUIRED: Your Child's Story

Please provide us with some information about your child and why this funding is important to everyone involved in your child's care. The information can include but is not limited to:

1. How the funding you requested will improve your child's and family's quality of life
2. How the funding you requested will improve the long-term outlook for your child
3. The financial barriers to receiving necessary care/equipment
4. Your child's personality traits, prognosis in therapy, treatment history, and treatment goals
5. 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.

End Parent/Guardian part of application. Please ask your child's therapist or provider to complete Part 2 (pages 4-6). Part 1 and Part 2 must be completed and signed to submit the application to Elevations.

PART 2: To be completed by **EACH Therapist or Provider** supporting this child's application to Elevations

Therapist or Provider Name: _____

Clinic/Place of Employment: _____Phone: _____

I provide services in Spokane County, 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. Please indicate your requests below as specifically as possible.

_____ PT visits or $_____ to fund PT services

_____ OT visits or $_____ to fund OT services

_____ Speech visits or $_____ to fund Speech services

_____ Mental Health visits or $_____ to fund Mental Health services

_____ Behavioral Therapy visits or $_____ to fund Behavioral Therapy services

_____ Dietician/Nutrition visits or $_____ to fund Dietician/Nutrition services

_____ Hippotherapy visits or $_____ to fund Hippotherapy services

_____ Music Therapy visits or $_____ to fund Music Therapy services

_____ _____ visits or $_____ to fund _____ services

Equipment: _____ at a cost of $_____
(must provide website/photo/ordering information)

TOTAL AMOUNT REQUESTED $_____

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___**

Does the family have a Medicaid plan as primary, secondary, or tertiary? **Yes___ No___**

REQUIRED: Please provide any **additional information and/or justification** for this funding request. If requesting equipment, provide information about a trial of the equipment and the child's response.

REQUIRED: Therapist or Provider Signature

I have discussed this request for funding with the family and support this application. **Y___ N___**

_____ _____

Therapist or Provider Signature Date