Application Packet

2020 Grant Schedule:

Applications Due April 22, 2020
Grants Awarded May 8, 2020

Applications Due October 21, 2020
Grants Awarded November 6, 2020

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. Prior to disbursing funds, Elevations requires each provider to have a current provider agreement with Elevations in place. This document is available on the website, www.elevationsspokane.org.

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!

Child's Name: _____

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 one year after the award.

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

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

Child's Diagnosis: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number(s): _____ _____

Email address: _____

Signature of parent/guardian

_____ _____

Parent/Legal Guardian signature Date

Child's Name: _____

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: _____

Does your child have access to DDA (Developmental Disabilities Administration) funds? **Y___ / N__**

Does your child have access to SSI (Supplemental Security Income) funds? **Y___ / N___**

Your <u>Specific</u> Request to Elevations for Funding- what do you need help with?
(number of visits, number of copays and amount, specific equipment, other request)

_____ **AND** Total Amount: $_____

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

Child's Name: _____

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. The entire application must be completed and signed by parent/guardian and therapists/providers to submit to Elevations.

Child's Name: _____

PART 2: To be completed by the therapy provider. If the child is applying for funds for more than one service, EACH provider must complete page 5.

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.
SHOW YOUR WORK so we can best understand your request.
Attach additional pages as necessary.

_____ 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 specific ordering information- print "cart". Please include shipping costs.)

TOTAL AMOUNT REQUESTED $_____

Child's Insurance Information:

Insurance Carrier: _____

Does this insurance carrier provide coverage for therapy services? **Y___/N___**
Equipment? **Y___/N___**

Visits allowed per year: _____ Copay per visit: _____

Annual deductible: _____ Annual Out of Pocket Expense: _____

Does this family have a Medicaid plan as primary, secondary, or tertiary? **Y___ / N___**

Child's Name: _____

REQUIRED: Therapist: Please provide **information and/or justification** for this funding request. Each requesting therapist must complete and sign this form.

Therapist or Provider Name: _____

Clinic/Place of Employment: _____Phone: _____

I provide services in Spokane County, WA **Y___ / N___**

I am licensed in Washington as a/an _____.

Email Address: _____

Service I provide for this child: _____

1. This child consistently attends therapy appointments. **Y___ / N___**
2. This child's family demonstrates consistent follow through with home program activities. **Y___ / N___**
3. This child demonstrates good progress toward therapy goals. **Y___ / N___**
4. I recommend this child continue therapy services. **Y___ / N___**
5. I have discussed this request for funding with the family**. Y___ / N___**
6. I would like to discuss this application with an Elevations Awards Committee member. **Y___ / N___**
7. My clinic has a provider agreement with Elevations**. Y___ / N___**
8. **Information and/or Justification:**

Equipment Requests:
This child has tried the requested equipment during therapy sessions. **Y___ / N___**

Number of sessions/**trials** with requested equipment: _____

Child's **response** to trials: _____

_____

_____

_____

Therapist or Provider Signature

_____ _____

Therapist or Provider Signature Date