elevations
a children's therapy resource foundation

To fund necessary therapies to elevate children with special needs

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. Grant awards are not guaranteed and may be less than the requested amount.

If you are awarded grant funds, you agree to answer a brief survey one year after the award.

Grant Application

PART 1: To be completed by **parent or legal guardian** (please print legibly)

Child's Name: _____ Date of Birth: _____ Age: ____

Child's Diagnosis: _____

Parent/Legal Guardians: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone Number(s): _____

Email Address: _____

Signature of parent/guardian

_____ _____

Parent/Legal Guardian Signature Date

This application is for

☐ Helping pay for therapy visits
☐ Therapy equipment
☐ Tuition/fees for a therapy program
☐ Other

Child's School and Therapy Information

Name of School: _____ District: _____ Grade: _____

My child receives therapy services through the school district: ☐ Yes ☐ No

- If yes:
  ☐ PT ☐ Speech Therapy ☐ Other_____
  ☐ OT ☐Other: _____ ☐ Other_____
- If no, why not: _____

Outpatient Therapy Services

☐ PT Frequency?_____ Therapist: _____ Clinic: _____

☐ OT Frequency?_____ Therapist: _____ Clinic: _____

☐ Speech Frequency?_____ Therapist: _____ Clinic: _____

☐ Feeding Frequency? _____ Therapist: _____ Clinic: _____

☐ _____ Frequency?_____ Therapist: _____ Clinic: _____

☐ _____ Frequency?_____ Therapist: _____ Clinic: _____

Does your child have access to other funds (e.g. DDA, SSI, other)?* ☐Yes ☐No Source: _____

What are these funds used for?* _____

**Questions about other funding sources do not affect your eligibility for an Elevations grant. It helps us with data collection about resources and unmet needs in Spokane County.*

Your <u>Specific</u> Request to Elevations – What are you asking for? (Ask your clinic for help if you don't know amounts.)

Equipment (Tell us more in Your Child's Story) Amount: _____

Deductible (How many visits will it take to fill your deductible) _____ Amount: _____

CoPays/Co-insurance for #_____ visits at $_____ each Amount: _____

____ visits at contracted rate (e.g. no insurance or have maxed out visits) Amount: _____

Other: _____ Amount: _____

Total Amount: _____

I have discussed this request for funding with my child's therapist/provider ☐ Yes ☐ No

Therapist I talked to: _____

Birth to Three Years Only: I have a Family Resources Coordinator ☐ Yes ☐ No

If not, why not?_____

I have discussed this request with my Family Resources Coordinator ☐ Yes ☐ No

REQUIRED: Your Child's Story

Please tell us 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. The financial barriers to receiving necessary care/equipment
3. Your child's personality traits, prognosis in therapy, treatment history, and treatment goals
4. If you are requesting funding for equipment, please tell us about how your child has trialed the equipment and what you observed.

☐ Initial application; please tell us about your child and your request!
☐ Renewal application. Please give us a brief update on your child since your last application. We'd love to hear how a grant has helped your family.

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

End Parent/Guardian part of application. Please ask your clinic and child's therapist to complete Part 2. The entire application must be completed and signed by a parent/guardian and therapists/providers, and all parts submitted by the deadline.

THERAPIST PORTION (Must be completed by each discipline requesting funds)

Child's Name_____

Therapist/Provider Name: _____

Clinic/Place of Employment: _____ Phone:_____

I provide services in Spokane County (required) ☐ Yes

I am licensed in Washington State as a _____

E-mail _____

Service I provide for this child _____

This child consistently attends therapy appointments.	☐ Yes	☐ No
This child's family demonstrates consistent follow-through with home program activities.	☐ Yes	☐ No
This child demonstrates good progress toward therapy goals.	☐ Yes	☐ No
I recommend this child continue therapy services.	☐ Yes	☐ No
I have discussed this request for funding with the family.	☐ Yes	☐ No
I would like an Elevations staff member to contact me about this application.	☐ Yes	☐ Not necessary

Information/Justification (Attach more information if necessary). Please advocate for this child.

Prognosis: This child is likely to need therapy for ☐ less than 12 months or ☐ more than 12 months.

Equipment Requests (Attach a copy of a shopping cart showing full purchase costs and including a link to the vendor.)

This child has tried the requested equipment during therapy sessions. ☐ Yes ☐ No

Number of or length of time with trials _____

This equipment will likely be able to serve the child ☐ less than 12 months ☐ more than 12 months.

Child's response to trials:

Therapist or Provider Signature

_____ _____

Signature Date

Clinic Administration Portion

Child's Name_____

FUNDING WORKSHEET:

Does this family have a Medicaid plan as primary, secondary, or tertiary coverage? ☐ Yes ☐ No

Does this child have money from a previous Elevations Grant? ☐ Yes ☐ No

What is the remaining balance? $_____

As well as you can estimate, will this money be used by next grant date? ☐ Yes ☐ No

Comments _____

Child's Insurance Information

Insurance carrier: _____

Does this insurance carrier provide coverage for the child's therapy? ☐ Yes ☐ No ☐Partial

Explain partial coverage:_____

Does this insurance cover any equipment requested on this application? ☐ Yes ☐ No

What is the annual deductible? _____ Annual out-of-pocket expense_____

At the child's current visit rate, how many visits will be applied to deductible?

Number of visits *Therapy 1/#* _____ *Therapy 2/#* _____ *Therapy 3/#* _____ *Therapy 4/#*_____

What is the total cost of the visits applied to the patient deductible?

Cost of visits *Therapy 1/$* _____ *Therapy 2/$* _____ *Therapy 3/$* _____ *Therapy 4/$* _____

Copays, or Co-insurance after deductible is met

Number of visits *Therapy 1/#* _____ *Therapy 1/#* _____ *Therapy 1/#* _____ *Therapy 1/#* _____

Cost of visits *Therapy 1/$* _____ *Therapy 2/$* _____ *Therapy 3/$* _____ *Therapy 4/$* _____

Is there a visit limit for any therapies?

Number of visits *Therapy 1/#* _____ *Therapy 2/#* _____ *Therapy 3/#* _____ *Therapy 1/#* _____

Cost of therapy visits after benefit maximums are met

Cost of visits *Therapy 1/$* _____ *Therapy 2/$* _____ *Therapy 3/$* _____ *Therapy 3/$* _____

What is the family's total annual expense, given your best estimate, for therapy for this child? _____

Please be specific. What is your request for this application?

Estimated expenses for the family from _____ (date) to _____ (date)

Request for therapy expenses (from worksheet above)

To cover deductible, co-insurance, and/or copays, this child needs $_____

Child's insurance won't be billed (e.g. no insurance; no coverage; benefits maxed; aging out of 0-3).

Child needs _____ visits at contracted rate for a total of $_____

Request for Equipment – Please attach a copy of a shopping cart showing full purchase costs. (Also, please include a link with the vendor's name. This helps immensely with ordering equipment.)	
Cost of requested equipment (Equipment -_____)	$_____
Shipping and handling	$_____
Tax	$_____
Total Equipment Cost	$_____
TOTAL AMOUNT REQUESTED ON THIS APPLICATION	$_____