The disbursement of funds from special Kids Therapy, Inc. to recipients up to the age of 22 will consist of an application and the guidelines set forth in that application.

Upon receipt of application, information provided will be reviewed, and if necessary, verified. However, the approval of the application depends solely on the preceding information as other circumstances may apply.

If the applicant's request exceeds the available funds of the organization, *the request may be tabled until such funds become available or partial funds may be awarded*. With applications that are denied, a letter will be sent to the applicant regarding the decision. Applicants who wish to reapply must provide additional documentation that the child or family's circumstances have changed or that all other possible alternatives have failed.

By awarding finances, Special Kids Therapy, Inc. is making no recommendation as to the appropriateness or safety of a particular service for each applicant. Special Kids Therapy, Inc. is not responsible for the safety and progress of the child. Each family is strongly urged to consult with their physician and therapists regarding the choice and use of a particular service.

We will not give out names or any other information on any applications or requests received.

CHECK LIST:

	1. A recent letter from the child's physician stating that the applicant is medically capable of the service you are requesting.
	2. A letter of denial from the child's insurance provider, which states that the requested service was denied and a copy of insurance verification/cards.
	3. A letter from the school confirming enrollment if over 18.
	4. An invoice from the service provider and dates of attendance. (payment will be made directly to the provider)
	5. Completed application with your signature.

The above information is required – applications that are not completed in full or missing required information will not be reviewed until complete.

_____ YES Special Kids Therapy may use photos for general purposes
Such as brochures, online webpage, newsletters or publicity.

_____ NO Special Kids Therapy may not use photos.
(Please initial the appropriate answer)

MAIL APPLICATION AND REQUIRED INFORMATION TO:

Special Kids Therapy
1700 E Sandusky
Findlay, OH 45840

Special Kids Therapy would like to hear about the service you are selecting and your success stories. Your experience may benefit another family. If you wish to share a picture of the applicant, we will be proud to add him/her to our scrapbook of very special people.

FOR OFFICE USE ONLY: #

DATE RECEIVED	REQUEST AMT	AWARD AMT	DATE PAID	

APPLICANT INFORMATION:

Applicant Name: _____

Date of Birth: _____Sex: _____

Street Address: _____

City: _____Zip:_____County:_____

PARENT/GUARDIAN INFORMATION:

Primary Caregiver's Name(s):_____

Relationship to applicant: _____

Caregiver's address if not same as Applicant:

Street Address: _____

City: _____Zip:_____County:_____

Home phone: _____Work:_____Cell:_____

E-mail:_____

Information for Additional Caregiver if Special Kids Therapy will be working with a caregiver other than the parents/primary caregiver.

Address:_____Phone:_____

E-mail:_____

Applicant's Diagnoses:_____

_____

_____

_____

Complications related to diagnoses:_____

_____

_____

ASSISTANCE REQUEST:

Specific service requested (please provide exact name of the **1.)Service requested**, the **2.) Name of the provider**, and **3.)Name, address, and telephone number of the vendor** where service will be received.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Estimated cost of service: _____

1. Has applicant received funds from another source:_____

2. Please list other sources that will provide a portion of the funding for the service you are applying for and provide information regarding all steps taken to obtain this service for the applicant (other organizations attempted, church, family, letters of denial, etc):

_____

_____

_____

_____

_____

_____

3. Is applicant covered by parent/guardians commercial insurance: _____
(If coverage is denied by insurance carrier, please attach copy of insurance card along with denial)

4. Is applicant on Medicaid:_____
(Please attach a copy of a valid and current Medicaid card for the applicant)

5. Has applicant previously applied for or received a scholarship from Special Kids Therapy:_____

6. Has applicants county of residence been involved with any SKT programs:_____

7. Is there more than one child in the family with a disability:_____ (*if yes, what is the disability and age of the child)*_____

_____

8. Is applicant requesting equipment:_____Is it required for inclusion in daily living:_____

9. Will the therapy/activity or equipment be used in the State of Ohio:_____

10. Has the family of the requesting applicant been involved in other SKT programs:_____

_____

Due to the volume of applications and staff limitations, status reports are not provided and incomplete applications will not be reviewed unless there are unused funds. The final decision will be made by the Scholarship Committee.

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By submitting this application you attest that the information you have provided in this application is factual and true to the best of your knowledge and you indemnify and hold harmless Special Kids Therapy, Inc. and/or its staff or volunteers from any and all liability, claims, damage or injury sustained by applicant.

Signature: _____ Date: _____