Act4Me

A Chance for Therapy, Inc.

Grant for Therapy or Home Therapy Supplies Application Form - Part B

APPLICANT'S / CHILD'S GENERAL INFORMATION

LAST NAME: _____FIRST NAME:_____
CURRENT AGE :_____DATE OF BIRTH:_____GENDER :M_____F_____
RACE/ETHNICITY: (*CHECK ALL THAT APPLY)*
NATIVE AMERICAN/AMERICAN INDIAN/ ALASKA NATIVE ___ ASIAN ___ BLACK OR AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ___ WHITE ____
MIDDLE EASTERN/NORTH AFRICAN ___ OTHER ___ OTHER MIXED RACE ____
LATINO/HISPANIC/SPANISH ORIGIN ___ PREFER NOT TO ANSWER ____
DIAGNOSIS_____
WHAT TYPE OF THERAPY ARE YOU SEEKING? (CHECK ONLY ONE)
PHYSICAL:_____OCCUPATIONAL:_____SPEECH:_____
SOCIAL SECURITY # :_____DATE OF APPLICATION:_____
HOW DID YOU HEAR ABOUT ACT4ME?:_____

PARENT / GUARDIAN'S GENERAL INFORMATION

GUARDIAN #1- SPECIFY RELATIONSHIP TO CHILD: _____

LAST NAME: _____FIRST NAME:_____
MARITAL STATUS :_____ SOCIAL SECURITY: _____
STREET ADDRESS:_____ APT #:_____
CITY:_____STATE:_____ ZIP CODE: _____
EMPLOYER'S NAME / ADDRESS: _____
CITY:_____STATE:_____ ZIP CODE: _____
HOME TEL: _____CELL TEL:_____
WORK TEL:_____ E-MAIL: _____

GUARDIAN #2 - SPECIFY RELATIONSHIP TO CHILD: _____

LAST NAME: _____FIRST NAME:_____
MARITAL STATUS :_____ SOCIAL SECURITY:_____
STREET ADDRESS:_____APT #:_____
CITY:_____STATE:_____ ZIP CODE: _____
EMPLOYER'S NAME/ADDRESS:_____
CITY:_____STATE:_____ ZIP CODE:_____
HOME TEL: _____CELL TEL: _____
WORK TEL:_____ E-MAIL: _____

ACT4ME . 260 CRANDON BLVD . SUITE 32-222 . KEY BISCAYNE . FLORIDA 33149

OTHER DEPENDANT'S INFORMATION (NOT APPLICANT)

NAME # 1: _____RELATIONSHIP TO APPLICANT:_____
AGE: _____ANY SIMILAR DIAGNOSIS/DISABILITY: _____
NAME # 2: _____RELATIONSHIP TO APPLICANT:_____
AGE: _____ANY SIMILAR DIAGNOSIS/DISABILITY: _____
NAME # 3: _____RELATIONSHIP TO APPLICANT:_____
AGE: _____ANY SIMILAR DIAGNOSIS/DISABILITY: _____

FAMILY SITUATION / BRIEF DESCRIPTION

_____
_____
_____
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APPLICANT / CHILD'S MEDICAL INFORMATION

CURRENT DIAGNOSIS: _____
DATE OF DIAGNOSIS:_____DIAGNOSED BY(PHYSICIAN'S NAME): _____
SPECIALTY:_____TEL: _____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
ARE THERE ANY OTHER PHYSICIANS INVOLVED IN CHILD'S TREATMENT? YES____NO____
NAME:_____SPECIALTY:_____TEL:_____
NAME:_____SPECIALTY:_____TEL:_____
NAME:_____SPECIALTY:_____TEL:_____

SCHOOL ATTENDED BY APPLICANT

NAME:_____ADDRESS: _____
TEL:_____TEACHER'S NAME:_____GRADE:_____
DOES THE APPLICANT HAVE A SCHOOL IEP? Y_____N_____
IF YES, WHAT PROGRAM(S) IS SHE/HE IN? _____
IS THE APPLICANT CURRENTLY RECEIVING THERAPY AT SCHOOL? Y_____N_____
PHYSICAL: Y_____N_____ HRS WEEKLY:_____
OCCUPATIONAL: Y_____N_____ HRS WEEKLY:_____
SPEECH: Y_____N_____ HRS WEEKLY:_____

PRIVATE THERAPY ATTENDED BY APPLICANT

IS YOUR CHILD CURRENTLY RECEIVING PRIVATE THERAPY? Y_____N_____
PHYSICAL: Y_____N_____ HRS WEEKLY:_____
PROVIDER'S NAME: _____TEL:_____
OCCUPATIONAL: Y_____N_____ HRS WEEKLY:_____
PROVIDER'S NAME: _____TEL:_____
SPEECH: Y_____N_____ HRS WEEKLY:_____
PROVIDER'S NAME: _____TEL:_____

FAMILY INCOME INFORMATION

GUARDIAN # 1 GROSS YEARLY INCOME: _____
GUARDIAN # 2 GROSS YEARLY INCOME: _____
OTHER SOURCE AND AMOUNT OF YEARLY INCOME: _____
_____

APPLICANT'S / CHILD'S HEALTH INSURANCE COVERAGE

INSURANCE NAME: _____
INSURANCE ADDRESS: _____
CONTACT PERSON:_____TEL:_____
I.D NUMBER:_____ GROUP NUMBER: _____
PRIMARY INSURED: _____RELATIONSHIP: _____
IS ANY TYPE OF THERAPY COVERED UNDER YOUR INSURANCE? Y_____N_____
IF YES, WHAT KIND OF THERAPY AND HOW MANY SESSIONS PER YEAR?
_____
CAN YOU REQUEST ADDITIONAL SESSIONS WITH YOUR INSURANCE ? Y_____ N_____

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

THIS AUTHORIZES THE USE AND/OR RELEASE OF THE PROTECTED HEALTH INFORMATION AS NOTED ABOVE FOR PURPOSES OF THE GRANT REVIEW PROCESS BY ACT4ME, INC. I _____
RELATIONSHIP TO APPLICANT: _____(PRINT NAME)
GIVE PERMISSION TO ACT4ME, INC., ITS BOARD OF DIRECTORS AND/OR GRANT REVIEW COMMITTEE, TO VERIFY ALL MEDICAL HISTORY, INSURANCE COVERAGE AND TREATMENT INFORMATION, BY CONTACTING THE PROVIDERS DIRECTLY. I RESERVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING TO ACT4ME, INC.,AT ANY TIME, USING CERTIFIED MAIL WITH RETURN RECEIPT. THIS WILL ALSO CANCEL THE GRANT REVIEW PROCESS, APPLICATION & AWARD.

DATE:_____GUARDIAN # 1- SIGNATURE:_____

DATE:_____GUARDIAN # 2- SIGNATURE:_____

HOME THERAPY SUPPLIES

FUNDS MAY BE REQUESTED FOR DIRECT TREATMENT WITH THE CHILD'S THERAPY PROVIDER FOR A ONE TIME GRANT AMOUNT NOT TO EXCEED $3,500.00
OR FOR HOME THERAPY SUPPLIES NOT TO EXCEED THE SAME VALUE AMOUNT.
MY GRANT REQUEST APPLIES TO:

DIRECT TREATMENT: YES_____NO_____

OR

HOME THERAPY SUPPLIES: YES_____NO_____

PLEASE DESCRIBE BELOW THE ITEM YOU ARE REQUESTING. MAKE SURE TO INCLUDE THE DESCRIPTION OF THE ITEM, THE VENDOR, AND THE COST. YOU MAY USE AND ATTACH A SEPARATE SHEET IF REQUIRED.

_____
_____
_____
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_____
_____

SIGNATURES OF GRANT REQUEST

ARE YOU CURRENTLY REQUESTING A GRANT(S) FROM ANOTHER ORGANIZATION?
YES____NO____ IF YES EXPLAIN:_____
_____
_____
_____
HAVE YOU EVER REQUESTED A GRANT FROM ACT4ME, INC.? :
YES____NO____ IF YES EXPLAIN:_____
_____
_____
_____

I _____ CERTIFY THAT ALL INFORMATION INCLUDED IN THIS APPLICATION IS TRUE AND VERIFIABLE.

_____
SIGNATURE OF PARENT/GUARDIAN# 1 DATE

_____
SIGNATURE OF PARENT/GUARDIAN# 2 DATE