High Hopes Therapy Clinic Financial Assistance Application

Child's Name		Child's Date of Birth
Home Address (Number, Street, City, Zip Code)		
Home Phone	Application Date	FOR OFFICE USE ONLY DATE APPLICATION WAS RECEIVED INITIALS

Mother or Guardian Name	Home Address (if different than above)
Name of Employer	Email address
Primary Phone	Cell Phone
If student: University, College or Job Training Name and Address	

Father or Guardian Name	Home Address (if different than above)
Name of Employer	Email address
Primary Phone	Cell Phone
If student: University, College or Job Training Name and Address	

Diagnosis: _____

Current therapy (ies) received, frequency, therapist, funding source (insurance, private pay, etc.):

Therapies	"X" if Received	Frequency	Therapist	Funding Source
PT				
OT				
ST				
FT				

Recommended Therapy (ies), frequency, and what therapist made the recommendation:

Therapies	"X" if Recommended	Frequency Recommended	Recommending Therapist
PT			
OT			
ST			
FT			

Please provide a brief description of why you are applying for financial assistance for therapy specifically related to recommendations for therapy and inadequate insurance coverage/funding. _____

_____

_____

What steps have you taken to attempt to improve insurance funding for recommended therapy (ex. Physician Letters of Medical Necessity, appeals, discussions with Human Resources etc.)? _____

_____

_____

I give permission for representatives of High Hopes to contact my insurance company to verify benefits for therapy services.

_____ _____

Signature Date

_____

Printed Name

Health Insurance Company	**Insurance Company Phone Number from Back of Card**
Member ID	**Group Number**
Name of Person Who Carries Health Insurance (Subscriber)	**Subscriber DOB & Relation to Child**

Does the child currently receive services through Tennessee Early Intervention System (TEIS)? _____

Does the child currently qualify for therapy services through the public school system? If so, at what frequency is he/she receiving school system therapies? _____

Does the child have TennCare? _____ If so, circle which one? TennCare Select / Americhoice / Amerigroup

What other expenses, related to your child's diagnosis, do you regularly incur (ex. medical supplies, special formulas, medications, etc.)? _____

_____

_____

_____

_____

Have you applied for any grants or scholarships to cover the cost of medical expenses? YES☐ NO ☐

- *United HeathCare Children's Foundation Grant (UHCCF.org)* YES☐ NO ☐ Outcome_____
- *Health Well Foundation (1-800-675-8416)* YES☐ NO ☐ Outcome_____
- *First Hand Foundation (www.firsthandfoundation.org)* YES☐ NO ☐ Outcome_____
- *Helping Hand (www.nationalautismassociation.org/family-support/programs)* YES☐ NO ☐ Outcome_____
- *Other* _____ YES☐ NO ☐ Outcome_____

Total members in household:	Check If NO Income	**Total Household Gross Income – You must report how much**			
Name (first name, last name) List everyone in household including children		Monthly earnings from work before deductions	Monthly welfare, child support, alimony	Monthly pensions, retirement, Social Security	All other monthly income (Unemployment)
		How much?	How much?	How much?	How much?
Example: John Smith		**$500**	**$200**	**$100**	
Example: Jane Smith	**X**				
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

I certify that all information on this application is true and that all household income is reported. I understand that scholarship funds are awarded based on the information provided. I also understand that therapy administration will verify the information. I understand that if I purposely give false information, my child will lose any financial assistance awarded, and I will be responsible for the full cost of therapy.

Signature **Date**