Application for CPA Services

New______ Renewal______ *Please check one*

Name of Client: ______________________________**Birth Date**: ______________
Parent(s)/Guardian(s):
____
Address: ______________________________City______________________ **Zip Code**: _______
Is this address within the city limits of Colorado Springs? Yes_____ No_____ Not sure_______
Home Phone: _____________**Work**:_____________ **Cell**: ____________*Best time to call*______
E-Mail :____
***U.S. Citizen** or Legal Immigrant? Yes______ No______
***Client diagnosis: Cerebral Palsy_______ Neuro-Motor______ unknown_____**
***Family size: _____**
***Family's Income range: $0- $39,650___ $39,651- $50,000___ $50,001- $75,000___**
$75,001- $100,000___ over $100,000 ___
***This information is used primarily for statistics within our organization** (**no name will be used with this**)

Have you applied for SSI, or Medicaid? Yes _______ No ________
Status: Denied ____Waiting List ____ No Response to Date ____Other ____________________
Is child enrolled in therapy at school or other program? Please list name of school/program and frequency ____

(Stop here and sign ___________________________________…if NO $ assistance is needed)
****
-Is client covered under any health insurance, including Medicaid? Yes____ No_____
If yes, what does the insurance cover? ____
____
Name of Insurance Company ___________________________________Phone ______________
Name of Insured__________________________ Social Security # of Insured _______________
Has client been denied coverage by insurance? Yes________ No ________
If yes, include copy of denial letter.

-Have you requested assistance from any other agency? Yes ________ No ________
If yes, list ALL agencies, their response(s) and contact person. (i.e: The Resource Exchange, Shriner's, Friends of Man, etc.)
____
____

***SERVICES REQUESTING FUNDING ASSISTANCE*:**

Therapy: OT________ PT ________ Speech ________ Other________(camp, riding, etc.)
Specify - Other ____
How often: ___________________ Length of each session: _______________________
Estimated cost of service requested (per month or session) $__________________________
How much will your insurance pay? $ _______________What is your co-pay? ____________
***Total amount requested* (per month or session) $**________________
Of this amount, how much can you pay? $_______________________
Is client currently receiving therapy? Yes ____ No ____ Where? ________________________
Name of therapist(s) ____
Does client attend regularly per care plan? Yes ___ No ____

Does client follow home program recommended by therapist? Yes _____ No _____

If currently receiving therapy, please attach recent evaluation report from therapist

Comments: ____

EQUIPMENT REQUESTING FUNDING ASSISTANCE:

Describe Item and Cost: (Attach picture of item if possible)

____

____

Attach written estimate, prescription and medical justification of need.

How much will your insurance pay? $________________

What is your co-pay amount? $______________________

Total Amount Requested $__________________________

Of this amount, how much can you pay? $______________

Comments:____

RECREATION SERVICES REQUESTING FUNDING ASSISTANCE:

Therapeutic Riding: ___ amount: _______ where:________________ how long:__________

Campership: ___ amount:___________ where:__________________ how long:__________

Other: ___ amount: __________ where: _______________________ how long:__________

FINANCIAL INFORMATION

Place(s) of Employment:_______________________________________Military?____________

Annual Household Income (Gross): $_________________________

Total number in household: ___________

Please enclose a copy of most recent pay stub(s).

Signature ____ Date ____________________

CHECKLIST (Your application is not complete if the following information has not been sent.)

_____Is the form totally completed?

_____If available/applicable, have you included a copy of Insurance or other agency denials?

_____Have you included a copy of recent Therapy Evaluations?

_____Have you included a copy of estimate from provider (for equipment request)?

_____Have you included copies of household proof of income?

_____Have you signed the application?

For therapy renewals only: (Attach additional sheets as needed.)

What progress has your child made over the past year? Include a recent therapy progress summary from therapist.

____

____

____

What progress do you expect over the next year? New goals and plan as discussed with therapist.

____

____

____

****

OFFICE USE ONLY

DATE RECEIVED_________ INITIAL _________

INFO UPDATES____