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 for statistics within our organization (No names will be used)**

Have you applied for SSI, or Medicaid? Yes _____No _____Approved______

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 ____

if NO $ assistance needed… Stop here and sign ___________________________Date________

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-Is client covered under any health insurance, including Medicaid and Medicaid waiver?

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.)

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***SERVICES REQUESTING FUNDING ASSISTANCE*:**

Therapy: OT______ PT ______ Speech ______ Other types of therapy _________________
Specify – Other: ____

With Who:____________________Address:_______________________Phone:____________
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? __________
Of this amount, how much can you pay? $_______________________
***Total amount requested assistance with…* (per month or session) $**________________

Is client currently receiving therapy? Yes ____ Where? ______________________ No ____
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*:**
Please provide contact info: ____
____

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? $_______________________
Of this amount, how much can you pay? $______________
Total Amount Requested $_________________________
Comments:____

***RECREATION SERVICES REQUESTING FUNDING ASSISTANCE*:**
Please provide contact info

Therapeutic Riding: __ **amount:** ______ **where:**_______________________ **length** ______

Campership: __ **amount:**________ **where:**____________________________ **length**______

Other Recreation Services__ **amount:** _______ **where:** __________________ **length**______

Of this amount, how much can you pay? _____________**Total amount requested:**_________

FINANCIAL INFORMATION
Place(s) of Employment:_____________________________________
Military?____________
Annual Household Income (Gross): $ N/A

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)?
N/A _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.

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

Individual or Family Membership in the Cerebral Palsy Association is strongly encouraged.

Please let us know ***if*** this presents a hardship.

Family Membership $10/yr _______
Individual Membership $5/yr _______

This membership entitles your family to attend events, funding consideration, use of loan items and any other services offered by CPACS.

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OFFICE USE ONLY

DATE RECEIVED____________________ INITIAL _________

INFO UPDATES____