

Cerebral Palsy Association of Colorado Springs

Application for CPA Services

New _____ Renewal _____ Please check one

Name of proposed client: _____ Birth Date: _____

Parent/Caregiver: _____

Address: _____ Zip Code: _____

Is this address within the city limits of Colorado Springs? Yes _____ No _____ Not sure _____

Home Phone: _____ Work: _____ Cell: _____

E-Mail : _____ Best time to call? _____

Is client covered under any health insurance, including Medicaid? Yes _____ No _____

If yes, what does the insurance cover? _____

Name of Insurance Company _____

Name of Insured _____ Social Security # of Insured _____

Phone # of Insurance Company _____

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, Easter Seals, Shriner's, etc.)

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 _____

SERVICES REQUESTED (Please indicate which service(s) you are requesting)

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? _____

Of this amount, how much can you pay? \$ _____

Total amount requested (per month or session) \$ _____

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 if recommended by therapist? Yes _____ No _____

If currently receiving therapy, please attach recent evaluation report from therapist(s).

Comments: _____

EQUIPMENT REQUESTED

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: _____

FINANCIAL INFORMATION

Place(s) of Employment: _____ Military? _____

Annual Household Income (Gross): \$ _____

Total number in household: _____

U.S. Citizen? Yes _____ No _____

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 _____ DATE APPROVED _____ AMOUNT \$ _____

SERVICE _____ VENDOR _____

Revised June 2008