

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 _____

Status: Approved _____ Denied _____ Waiting List _____ No Response to Date _____

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* _____

-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.) _____

Do not fill these sections out unless you NEED funding assistance for the section.

THERAPY- 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 the total amount, how much can you pay? \$ _____
Balance 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 the total amount, how much can you pay? \$ _____

Balance Amount Requested \$ _____
Comments: _____

RECREATION SERVICES REQUESTING FUNDING ASSISTANCE:

Please provide contact info if funding assistance is needed

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.

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.

I, _____ authorize CPACS to use (anonymous) pictures of my family/child for their website, publications, or posting in our office??

sign _____ date _____

OFFICE USE ONLY

DATE RECEIVED _____

INITIAL _____

INFO UPDATES _____