Financial Grant Application For OT/PT/SLP Assessment

Thank you for your interest in applying for a grant from Dyspraxia DCD America, a nonprofit 501(c)3 charitable organization dedicated to raising awareness, providing support and advocating for those impacted by Dyspraxia/DCD. At this time, Dyspraxia DCD America is awarding a grant to assist with Assessments for Dyspraxia/DCD by an Occupational Therapist (OT), a Physical Therapist (PT) and/or a Speech-Language Pathologist/Therapist (SLP). Applicants who are selected to receive a grant will be provided funds in accordance with the organization's guidelines and policies. Read additional information at Financial Grant Guidelines.

Every section of the application must be completed. All requested items must be submitted with your application.

If you have questions, contact **rachel@dyspraxiadcdamerica.org.**

Checklist of Attachments to Application

Required:

- ☐ Documentation supporting why you think your child has Dyspraxia/DCD (Check one or more.)
  - ☐ Developmental Coordination Disorder Questionnaire (Ages 5-15)
  - ☐ Checklist - Indicators of Dyspraxia/DCD in Children
  - ☐ Checklist -Indicators of Dyspraxia/DCD in Teens/Young Adults.
  - ☐ Observation Checklist for Parents To Share With Teachers

- ☐ Formal quote detailing the scope of the OT/PT/SLP Assessment(s)
  The quote must be provided by the healthcare provider on professional letterhead and must be current (dated within six months of the date of this application).

- ☐ Documentation of Insurance Coverage or Non-Coverage, as applicable, to include:
  - ☐ Name of Insurance Provider
  - ☐ In-/Out-Of Network Costs related to
    - ☐ Deductible
    - ☐ Copay

- ☐ Family Income verification
  - ☐ IRS 1040 Federal Tax Returns for the past two years
  - ☐ If not required to file an IRS 1040 Federal Tax Return
    - ☐ Documentation of nontaxable income for the past two years

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Optional:

- ☐ Any other documentation that you'd like to share - Your observations, childcare or educational provider's comments/observations, anecdotal notes, etc.

Child/Family Information

Child's Name: _____

Child's Date of Birth _____

(The child must be at least five years of age as of the application deadline in order for the application to be considered.)

Parent/Guardian Name: _____

Relationship to child: _____ Employed: _____ Yes _____ No

Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

E-Mail: _____

Child lives with:

_____ Both Parents/Guardians _____ Primary Parent/Guardian only

_____ Other If other, describe: _____

Number of children living in the home, including applicant: _____

Primary language spoken in the home:

_____ English _____ Spanish _____ Other _____

Current Total Household Annual Income

(**Gross income**)

_____ Under $30,000

_____ $30,000 - $49,999

_____ $50,000 - $74,999

_____ $75,000 - $99,999

_____ $100,000 - $125,000

_____ $125,000 - $149,999

_____ $150, 000 and above

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Healthcare Provider Information

The Parent/Guardian must identify and contact the desired healthcare provider to obtain a formal quote detailing the scope of the OT/PT/SLP Assessment(s). The quote must be current and on the provider's professional letterhead.

Name of OT/PT/SLP: _____

Name of Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

E-Mail: _____

Insurance

Is the applicant covered by insurance for the requested services?

- ☐ Yes, we have coverage that includes OT/PT/SLP Assessment(s) for Dyspraxia/DCD. I have included copies of the insurance documentation that confirms:
  - ☐ $_____ Annual deductible per individual
  - ☐ $_____ Coinsurance or copay
- ☐ No, we do not have insurance that covers OT/PT/SLP Assessment(s) for Dyspraxia/DCD. I have included copies of information from my insurance company that confirms the exclusion of OT/PT/SLP Assessment(s) for Dyspraxia/DCD.:
  - ☐ The language in the Summary Plan Description that describes what is covered and what is excluded is attached.
  - ☐ Other: _____

Healthcare Provider

- ☐ I am choosing an in-network provider.
- ☐ I am choosing an out-of-network provider because:
  - ☐ There is not an in-network provider within 50 miles of my home.
  - ☐ There are no in-network providers who offer OT/PT/SLP Assessments of Dyspraxia/DCD.
  - ☐ Other: _____

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Income/Federal Tax Returns

- If single, send the Parent's/Guardian's IRS 1040 Federal Tax Returns for the past two years.
- If married and filing jointly, send the IRS 1040 Federal Tax Returns for the past two years.
- If married and living in the same household, but filing separately, send both adults' IRS 1040 Federal Tax returns for the past two years.
- If the Parent/Guardian is not required to file an IRS 1040 Federal Tax Return, attach verification of nontaxable income for the past two years.
- **Block out all social security numbers.**

$_____ Total Annual Household Income from the IRS 1040 Federal Tax Returns for the past two years **OR** applicable SSI payments.

- ☐ I have included a copy of my(our) IRS 1040 Federal Tax Returns for the past two years.
- ☐ I am not required to file an IRS 1040 Federal Tax Return. Attached is documentation of my nontaxable income for the past two years..

_____ I have read and understand Dyspraxia DCD America's Privacy Notice and Terms of Service.

With my signature or electronic signature I understand that I agree to the Privacy Notice and Terms of Service and give Dyspraxia DCD America permission to contact all related healthcare professionals as mentioned in the application.

Signature of Parent/Legal Guardian _____

Printed Name of Parent/Legal Guardian _____

Date _____

_____ I verify that I am the above named person and the name I have provided is my own. I understand that false statements will immediately invalidate my application to Dyspraxia DCD America.

All materials provided with this application become the property of Dyspraxia DCD America and will not be returned.

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