



(for office use only) _____ - _____

Therapy Scholarship Application

Family Hope Foundation

7086 8th Avenue

Jenison, MI 49428

(616) 729-8833

www.familyhopefoundation.org

Please read the Scholarship Guidelines thoroughly before completing this application.

Every question must be answered for application to be complete.

Applications are due by March 1 or September 1.

You must submit three total stapled copies of this completed application.

Applicant Information:

1. Applicant's Name: _____
Last First

Any Previous Names (if applicable): _____

2. Birthdate: ____/____/____ 3. Age: ____ 4. M / F

5. Applicant's Primary Diagnosis: _____

6. Applicant's Secondary Diagnoses/Disabilities (list all): _____

7. Check the **ONE** disability category that most accurately represents the applicant (**do not check more than one**):

- | | |
|--|---|
| <input type="checkbox"/> Autism Spectrum Disorder or
Pervasive Developmental Disorder | <input type="checkbox"/> Sensory Processing Disorder (only) |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Severely Multiply Impaired |
| <input type="checkbox"/> Emotionally/Psychologically Impaired | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Physically Impaired | <input type="checkbox"/> Speech and Language Disability |

8. Briefly tell us about **who** the applicant is as a person (attach an additional page, if needed):

General Information:

9. Has applicant applied for a Family Hope Foundation scholarship in the past? ()Yes ()No

9a. If "Yes" to 9: Has applicant received a Family Hope Foundation scholarship in the past? ()Yes ()No

10. Are you willing to be the recipient of a *Gift of Hope* Scholarship (see guidelines)? ()Yes ()No

11. Therapy Provider (**list according to guidelines**): _____

12. How did you hear about Family Hope Foundation? _____

Applicant Name: _____

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Family Information:

13. Parties responsible for applicant: Parent(s) Guardian(s) Self

Last

First

Last

First

14. Address:

Street

City

State

Zip

15. County (not country): _____

16. Email _____

17. Phone: (_____) _____

Home

(_____) _____

Cell

18. Number of family members in home: Children _____ Adults _____

Financial Information: This is an application for financial assistance; you must prove financial need.

19. Amount of scholarship being requested: \$ _____ (not to exceed \$1,000)

20. What is the cost of therapy being requested? \$ _____ (per: hour/week/month)

21. Check the applicant's medical coverage (check all that apply):

Private Insurance Medicaid/MI Child Children's Special Health Care None

22. Will insurance cover any of the cost associated with this therapy? (Check your latest policy before answering!)

Yes No Applicant does not have any insurance coverage, as noted above.

22a. If "Yes" to 22, explain your coverage according to the guidelines: _____

23. Check which best describes your financial situation:

Two-parent, two-income (part or full-time) Single parent, single-income

Two-parent, single-income Single parent, no income

Two-parent, no income

Other _____

Disability income

24. Do you have multiple family members with special needs? No Yes, explain below:

25. Explain ANY of the circumstances that contribute to your FINANCIAL need for a scholarship, including items checked in the section above (attach an additional page, if needed):

Applicant Name: _____

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Therapy Information:

26. Name the type(s) of therapy being requested for this scholarship: _____

27. Therapy Provider **(list according to guidelines)**: _____

Therapy Provider Address:

_____ Street _____ City _____ State _____ Zip

Therapy Provider Phone: (____) _____

28. Has the applicant been evaluated by this provider: ()Yes ()No

29. Has the applicant received therapy from this provider: ()Yes, currently ()Yes, in the past ()No

30. List **all** therapies, including the above, that the applicant receives at **school (S)**, receives **privately (P)** or are **desired (D)** for the applicant and check the appropriate choice.

_____ ()S ()P ()D _____ ()S ()P ()D
_____ ()S ()P ()D _____ ()S ()P ()D

31. Is therapy being requested by a physician? ()Yes ()No

31a. If "Yes" to 31, please complete:

Physician: _____ Practice: _____

Address:

_____ Street _____ City _____ St _____ Zip

32. Please explain in detail why this therapy will be beneficial to the applicant (attach additional page, if needed):

Application Verification:

If applicant is selected to receive a scholarship, I commit to complying with all follow up requirements and paperwork submissions within one month of being notified.

_____ Signed _____ Date