



FINANCIAL ASSISTANCE APPLICATION

DATE RECEIVED: ____/____/____

APPLICANT: LAST FIRST MI AGE SEX

STREET CITY STATE ZIP CODE

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

| | NAME | SOCIAL SECURITY # | AGE | MARITAL STATUS |
|-----------|------|-------------------|-----|----------------|
| APPLICANT | | | | |
| MOTHER | | | | |
| FATHER | | | | |
| OTHER | | | | |

MOTHER/FATHER (circle one) ADDRESS & TELEPHONE # IF DIFFERENT THAN CHILD

WHO HAS LEGAL CUSTODY OF APPLICANT? (if applicable) _____

NAME OF NEAREST RELATIVE / FRIEND: _____

CONTACT TELEPHONE # OF FRIEND OR RELATIVE: _____

DO PARENTS SPEAK ENGLISH? _____ IF NOT, WHAT LANGUAGE? _____

SCHOOL CHILD ATTENDS: _____ PHONE #: _____

WHAT SERVICES ARE YOU REQUESTING FOR THIS CLIENT? (circle all that apply)

PHYSICAL THERAPY

THERAPEUTIC RIDING

COUNSELING

WHY DOES THE CLIENT NEED THE SERVICES (describe health or other problems of applicant)?

GIVE INFORMATION ABOUT THE PROFESSIONAL WHO PRESCRIBED THE NEEDED SERVICES

ADDRESS: _____

PHONE #: _____ CONTACT NAME: _____

HOW MUCH OF THE COSTS ARE YOU REQUESTING AS ASSISTANCE FROM ROCKY TOP THERAPY CENTER?

WHO WILL PAY THE DIFFERENCE BETWEEN THE TOTAL COST AND THE AMOUNT YOU ARE REQUESTING FROM ROCKY TOP THERAPY CENTER?

HAVE YOU RECEIVED ASSISTANCE FROM ROCKY TOP THERAPY CENTER BEFORE? _____

HOW DID YOU HEAR ABOUT ROCKY TOP THERAPY CENTER? _____

LIST OTHER COMMUNITY AGENCIES OR RESOURCES WHICH WERE CONTACTED FOR HELP BEFORE APPLYING TO ROCKY TOP THERAPY CENTER:

CHURCH _____

COMMUNITY: _____

AGENCY: _____

WHAT WAS THEIR ANSWER? _____

GIVE NAME, ADDRESS AND PHONE NUMBER OF PERSON WE MAY CONTACT AS A REFERENCE ON THIS REQUEST (i.e. MINISTER, DGR, EASTER SEAL WORKER, ETC.)

NAME ADDRESS PHONE #

NAME ADDRESS PHONE #

| | EMPLOYERS NAME | EMPLOYERS ADDRESS | EMPLOYERS TELEPHONE # | MONTHLY TAKE HOME EARNING |
|--|----------------|-------------------|-----------------------|---------------------------|
| FATHER | | | | |
| MOTHER | | | | |
| STEP PARENT (WITH WHOM CHILD IS LIVING) | | | | |

OTHER PEOPLE LIVING IN HOUSEHOLD (INCLUDING OTHER CHILDREN)

| NAME | KINSHIP TO CHILD | AGE | MARITAL STATUS | INCOME |
|------|------------------|-----|----------------|--------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

DOES PARENT / GUARDIAN HAVE OTHER INCOME OR FINANCIAL SUPPORT?

CHILD SUPPORT: _____ AMOUNT: \$ _____
 AFDC: _____ SOC. OR SSI: _____
 HOUSING: _____ AMOUNT: \$ _____
 WIC: _____ FOR WHOM: _____
 FOOD STAMPS: _____

PLEASE COMMENT ON ANY OTHER FINANCIAL OBLIGATIONS:

MONTHLY RENT: _____

CAR PAYMENTS: _____

MEDICAL EXPENSES: _____

OTHER HARDSHIPS:

(medical bills, o/s debt which may hinder your ability to pay for the services yourself)

IS THIS CLIENT COVERED BY ANY INSURANCE POLICY OR PROGRAM (INCLUDING MEDICAID)? _____

POLICY # _____ MEDICAID # _____

WHICH INSURANCE COMPANY?

IS THE POLICY THROUGH A GROUP PLAN AT PARENT'S PLACE OF EMPLOYMENT? _____

WHICH PARENT? _____

I ACKNOWLEDGE THAT ROCKY TOP THERAPY CENTER WILL RELY ON THE INFORMATION ON THE APPLICATION IN MAKING ITS DECISION ON THIS REQUEST. I AUTHORIZE ROCKY TOP THERAPY CENTER TO CONSULT WITH, OR RELEASE INFORMATION TO ANY PERSON WHOM THEY DEEM NECESSARY TO VERIFY THIS INFORMATION AND THE REQUEST. I UNDERSTAND IT IS SOMETIMES NECESSARY FOR ROCKY TOP THERAPY CENTER TO DO THIS IN ORDER TO MAKE ITS DECISION ON MY REQUEST.

SIGNATURE: _____ DATE: _____

IF SOMEONE OTHER THAN PERSON SIGNING ABOVE FILLED OUT THIS APPLICATION, PLEASE GIVE US THE FOLLOWING INFORMATION:

NAME : _____

ADDRESS: _____

RELATIONSHIP TO APPLICANT: _____

PHONE #: _____ AGENCY / TITLE : _____

NOTE: A copy of your latest income tax form must accompany your application in order to be eligible for our scholarship application process. Once all of the required information is received, an interview will be scheduled to discuss your application.

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