



The Children's TherAplay Foundation, Inc.

2021-2022 Scholarship Application

(a separate application is needed for each child)

Date of application: _____

****Application will NOT be reviewed without ALL required documentation****

**** I understand that the Scholarship is not effective until approved and in the interim the full fee for service amount will be the responsibility of the patient ****

Patient's Name: _____ Patient's Date of Birth: _____

Type of services patient is currently receiving from The Children's TherAplay Foundation, Inc.:

Physical Therapy Occupational Therapy

Parent/Guardian 1: _____

Parent/Guardian 2: _____

Home Address: _____

Home Address: _____

City, State, Zip: _____

City, State, Zip: _____

County: _____

County: _____

Phone: (Home) _____

Phone: (Home) _____

Phone: (Work) _____

Phone: (Work) _____

Cell: _____

Cell: _____

E-mail: _____

E-mail: _____

Insurance:

Insurance Co: _____

Insurance Co: _____

Policy/Group #: _____

Policy/Group #: _____

Ins. Co. Address: _____

Insurance Co. Address: _____

City/State/ Zip: _____ Telephone: _____

City/State/ Zip: _____ Telephone: _____

Insured's Name: _____ SSN#: _____

Insured's Name: _____ SSN#: _____

Insured's DOB: _____

Insured's DOB: _____

Insured's Relationship to Client: _____

Insured's Relationship to Client: _____



THE CHILDREN'S THERAPLAY FOUNDATION, INC. SCHOLARSHIP BILLING POLICIES

As a recipient of the Scholarship Program, I understand that:

- The average fee for physical and occupational services averages \$135.00-225.00 per hour. The Children's TherAplay Foundation, Inc. Scholarship Program is made possible because of a generous contribution from Indianapolis Indians Charities.
- Once my Scholarship Application is completed and processed, a determination will be made of my out of pocket payment for each date of service.
 - 1.) I understand that I am responsible for my co-payment or co-insurance amount on **every** date of service.
 - 2.) I understand that I am responsible for my insurance contractual amount of payment while meeting my patient deductible. (Note: if you need assistance in obtaining this information, it can be found on your insurance EOB.)
- Applicants will be notified of determination by November 15, 2021.

Signature

I have received, read, understand and will comply with The Children's TherAplay Foundation, Inc.'s Scholarship Policies above.

Signature

Date

(One copy for your records; the second should be signed and returned to The Children's TherAplay Foundation, Inc.)