



Financial Aid Application and Agreement

Now I Can Foundation

Ability Fund Scholarship Program

I am applying for assistance through Now I Can Foundation's Ability Scholarship Program. I understand that this program is made possible by community donations. I understand I am responsible to pay the co-pay amount determined by my insurance provider. I understand I am responsible to pay my account balance beyond any financial aid and/or what my insurance provider will cover. I understand that it is my responsibility to determine insurance provider coverage, and will not hold the Now I Can Foundation responsible for balances beyond what my insurance provider will cover. I understand that therapy services will be time-limited. I understand that a committee will review my request and determine my eligibility for funding through this program. I understand that I am not guaranteed financial aid by submitting this application. I understand that financial information is required to be considered.

By signing below, I indicate that I have read and agree with the terms and conditions of this application as stated

Parent/Guardian Signature: _____

Date: _____

Please fill out this form completely, and return to the Now I Can Foundation for financial aid consideration.

Patient Name: _____

Date of Birth: _____

Parent(s)/Guardian(s) Name(s): _____

Mailing Address: _____

City, State, Zip: _____

Primary Phone: _____

Primary Email: _____

Please include along with this signed application the following documentation:

- A letter to introduce yourselves to the review committee. Please include a brief patient history, household financial circumstances including significant financial events/situations (loss of employment, medical bills, etc), and any other factors you would like to have considered.
- Most recent W-2 statement(s).
- Unemployment benefit determination letter or most recent check stub.
- Documentation of any other income.

If you have insurance, please complete the following:

Name and Address of Insurance Provider: _____

Group or Plan #: _____

Policy #: _____

Subscriber ID# (Social Security #): _____

Annual Deductible: _____

Co-Pay: _____

If you have insurance, please indicate the reason for the financial aid application:

- Services and/or diagnosis is not covered
- Benefits are limited to _____
- Need assistance with deductible and/or co-pay
- Other (please specify): _____

Please provide the following regarding your monthly household income:

Primary wage earner's name and occupation:	Monthly gross pay:
Secondary wage earner's name and occupation:	Monthly gross pay:
Number of adults in household:	Number of children in household:

Please provide the following about THE PATIENT for statistical and grant review purposes only:

Patient Age:	Gender:
Ethnicity: Caucasian American Indian African American Asian Other:	
City and County of residence:	

Please provide the following about THE PARENTS/GUARDIANS for statistical and grant review purposes only:

Parent/Guardian Age:	Gender:
Ethnicity: Caucasian American Indian African American Asian Other:	
City and County of residence:	

Using a scale of 1 (not very) to 5 (very), please rate your level of stress regarding the following:

- The financial impact of raising your child with special needs 1 2 3 4 5
- The emotional stress of raising your child with special needs 1 2 3 4 5

Using a scale of 1 (do not agree) to 5 (strongly agree), please rate your experience regarding the following:

- "I frequently feel tired and overloaded." 1 2 3 4 5
- I feel stressed trying to balance work and family obligations." 1 2 3 4 5

By signing below I indicate that I have supplied the above information which is true and accurate to the best of my knowledge, and I provide permission for this statistical data to be utilized for evaluation and promotional purposes.

I also understand that if my child is approved for sponsorship by the Ability Fund program, and if at any time in the future my insurance company does pay in full for Now I Can therapies, those monies will be returned to the Ability Fund to be made available to others in need.

Parent/Guardian Signature:	Date:
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If I receive financial aid, I would like to help the Now I Can Foundation by being willing to help with the following:

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|---|--|---|
| <input type="checkbox"/> Fundraising | <input type="checkbox"/> Cleaning/Janitorial | <input type="checkbox"/> Construction/Building Projects |
| <input type="checkbox"/> Event Planning | <input type="checkbox"/> Special Projects | <input type="checkbox"/> Other: |