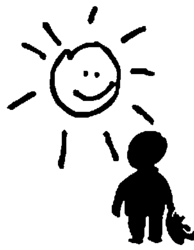

children's relief fund
APPLICATION FOR FUNDING

Child's Name:______________________________ Date of Birth:______________ Age:______

Diagnosis/Disability:____

Parent/Guardian Name & Address: ______________________________ Home Phone:__________

_____Single Parent Home ______________________________ Work Phone:__________
_____Both Parents in Home
_____Lives with Guardian ______________________________

Is this child covered under any of the following Companies or Agencies? ____None _____Medicaid

_____Health Insurance _____ Babynet _____CRS _____Other:____________________

Have you applied for insurance or financial assistance from other organizations? ____Yes _____No

If so, please list name of organization and date applied:________________________________

____

What school does child attend?______________________________ Grade?__________

Please check which special education services child receives at school? _____None _____Resource

Therapies: _______Physical _____Occupational _____Speech

What Services are you applying for:
_____ Physical Therapy
_____ Occupational Therapy
_____ Speech Therapy
_____ Assistance with Insurance Deductible
_____ Equipment/Other ($______________)

If you are applying for equipment or other items, please describe:__________________________

____

Other information regarding your need for financial assistance from CRF?____________________

____

What amount could you afford to pay each session ($10-$50)?______________________________

________________________________ ________________________________
Signature/Relation to Child Date

Post Office Box 22574 • Hilton Head Island, SC 29925 • 843-681-7668

The following information to be completed by Children's Relief Fund Board:

PT/OT/ST	# Units		Cost Per Unit		Cost Each Session		Sessions Per Week		Total Weekly Cost
________	______	x	$ ________	=	$ ________	x	________	=	$ ________
________	______	x	$ ________	=	$ ________	x	________	=	$ ________
________	______	x	$ ________	=	$ ________	x	________	=	$ ________

TOTAL WEEKLY THERAPIES: $ ________

PT/OT/ST	Total Weekly Cost Of Therapy		# Of Weeks		Total Cost Of Therapy
________	$ ________	x	________	=	$ ________
________	$ ________	x	________	=	$ ________
________	$ ________	x	________	=	$ ________

TOTAL COST OF THERAPY: $ ________

Family Payment Per Session		# Of Weekly Sessions		Weekly Family Payment		# Of Weeks		Total Family Payment
$ ________	x	________	=	$ ________	x	________	=	$ ________

TERMS AND CONDITIONS :

Total Cost of Therapy $ ________

Total Family Payment (-) $ ________

SUBTOTAL = $ ________

50% HHMC&C Discount (-) $ ________

Total CRF Commitment = $ ________

Terms to Begin: ________ **Terms To End:** ________

BOARD MEMBERS APPROVING:

________ ________ ________

________ ________ ________

________ ________

DATE OF APPROVAL: ________