www.speechpathwaysfoundation.org

Application for Grant/Scholarship

MISSION of the SPEECH PATHways Foundation

The mission of the SPEECH PATHways Foundation is to improve the lives of children who have communication disorders through grants/scholarships, parent and professional education, and support to the Carroll County community and surrounding areas. We strive to empower children of all ages to achieve their full communicative potential.

What are the grants?

The SPEECH PATHways Foundation supports and facilitates access to health-related speech and language services that would significantly enhance the quality of life of the children not fully covered by health insurance.

Interested in applying?

If you are interested in applying for a grant on behalf of your child, please note the following steps prior to applying:

1. **Read the criteria.** Prior to filling out the application you must meet the stated criteria. Applications that do not meet the criteria will not pass the initial screening process and will be closed.
2. **Read the checklist.** Prior to filling out the application please read the checklist to make sure you have the items you will need while filling out the online application.
3. Carefully fill out all required information.
4. Provide requested financial data which includes assets, liabilities and income.
5. Mail us requested paperwork. Please mail us the information in one, single packet. If you would like to know if we received your mailed information, please use a “delivery confirmation” or “tracking” service at the US Post Office, UPS, Fedex, DHL, etc.
6. Wait for the screening process. The screening process happens automatically throughout steps #3 and #4. If you pass the screening process, your child's application will automatically, and without notice, be passed on to step #6. If your child's application does not pass the screening process, you will be notified by mail and your application will be closed.

   Wait for the Board's decision. If your child's application meets the criteria and passes the screening process, the application and related information will be evaluated by the Board at their next Board meeting. The Board meets the fourth Friday of each month. It will take no more than 45 days to hear back from the Foundation. It is in your best interest to apply and mail us the requested information right away. Please be patient during this process.

7. Check your mail. You will hear back via mail if you are approved or are not approved. If you are approved, further instruction will be given on how to work with the Foundation.

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A Fund of the Community Foundation of Carroll County, Inc.
532 Baltimore Blvd., Ste. 403
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410-374-0555

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IMPORTANT: Please carefully read the grant eligibility criteria below.

In evaluating applications, the Board will consider applications based on the following criteria:

1. Grant applications requesting assistance for speech therapy unrelated to a serious medical condition are excluded from grant consideration.
2. The applicant must be between 1 - 16 years old and live within a 30 mile radius of Carroll County, Maryland.
3. The applicant must be covered by a health benefit plan and have exceeded coverage limits, or no coverage is available and/or the co-payments are a serious financial burden on the family. The SPEECH PATHways Foundation requires a commercial health benefit plan.
4. The potential of the intervention to significantly enhance the quality of life for the child, the financial status of the family and the severity of the child's illness.
5. Financial need of the child's family will be evaluated and documented through information provided on the application and by submission of a photocopy of the most recently filed Federal tax return (Internal Revenue Service 1040, 1040-A, or 1040-EZ). Generally, awards will be granted to individuals in families whose Adjusted Gross Income (AGI) does not exceed median income for the county of the family's residence.
6. Other financial resources to meet the health care needs are not available.
7. The amount awarded to an individual within a 12-month period is limited to either $5,000 or 25% of the fund balance, whichever amount is less. There are no lifetime maximums.
8. An application must be submitted prior to the child's 17th birthday.
9. The health care professional is to be paid directly.
10. Applications are to be reviewed by the Advisory Board which includes health care professionals appointed by the Foundation to determine the medical appropriateness of the treatment.
11. An application must be submitted to the Foundation prior to the receipt of services. The Foundation does not pay for past medical expenses.

Prepare to apply by reviewing the following checklist.

- Your child's social security number.
- Name and policy number of your child's current commercial health benefit plan.
- A detailed description of your child's medical condition.
- A description of the treatment, therapy, equipment or service your child's doctor or other health care professional has prescribed.
- The estimated total cost of the treatment, therapy, equipment or service.
- How much, if any, your insurance will help pay for.
- Doctor or health care professional's name, phone number and address.
- An outline of your finances - assets, income and expenses.
- The Foundation will request that paper work be sent to us via mail.

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Personal Information

Child's First Name

Child's Last Name

Child's Social Security Number
Example xxx-xx-xxxx

Child's Birthdate
Example MM/DD/YY

Parent/Guardian First Name

Parent/Guardian Last Name

Mailing Address

Address Line 1:
Street address, P.O. box, c/o

Address Line 2:
Apartment, suite, unit, building, floor, etc.

City

State
Select

Zip Code

Telephone Number
Example (xxx) xxx-xxxx

Work Telephone Number
Example (xxx) xxx-xxxx

Is this your first time applying for a grant from the SPEECH PATHways Foundation?
Select

E-Mail Address

Referral Source
How did you hear about the SPEECH PATHways Foundation?

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With whom does your child live? (List in table below)

Name	Age

Health Insurance and Medical Information

Name of Child's Health Insurance Company
Health insurance is required. Medicaid and other Federal or State subsidized insurance do not qualify.

What is the name of the Parent/Guardian that carries the insurance?

Child's Health Insurance Company Identification Number or Policy Number

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Name of Child's Dental Insurance Company

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What is the name of the Parent/Guardian that carries the insurance?

Child's Dental Insurance Company Identification Number or Policy Number

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Please provide a summary of the medical condition of the child.

What treatment, therapy, equipment or service has been prescribed for your child by your doctor or health care professional?

If you are requesting assistance with more than one item, please list them here and what their respective costs are.

Based on the costs listed above, how much or what percentage will your insurance company pay for?

What is the name of the doctor or health care professional that will administer or provide the treatment, therapy, equipment or service? If more than one, please list the child's primary physician or health care professional for this request.

What is the name of the clinic or facility?

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What is the phone number of the doctor or health care professional?

Doctor or health care professional Mailing Address

Doctor or health care professional City **Doctor or health care professional State** **Doctor or health care professional Zip Code**

Select

CONTINUE

What type of clinical or therapy services (if any) does your child receive currently – include private and school-based services?:

Type of Service	Frequency	Covered by Insurance	Out of Pocket Costs	Provider
Speech Therapy				
Occupational Therapy				
Physical Therapy				
Psychological/ Counseling				
Academic Tutoring				
Other:				

Please list any other miscellaneous expenses or extraneous financial expenses that you incur in the care of your child (example: specialized day care, diapers, other family members' medical situation, etc.)

_____

_____

_____

Please describe (in your own words) why you feel your child would benefit from private speech and language therapy? Please include what you hope your child will gain from private therapy and how you feel therapy may affect their life and the life of the family.

_____

_____

_____

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_____

_____

_____

_____

_____

COMMUNICATION STATUS

How would you describe your child's current communication ability?

_____

_____

_____

_____

_____

_____

Financial Statement

Number of people living in household:

ASSETS (FOR HOUSEHOLD)

ASSETS	
Cash in Checking/Savings Account	$
Investments [401(k), IRA's, Other]	$

MONTHLY INCOME AND EXPENSES (FOR HOUSEHOLD)

MONTHLY INCOME		**MONTHLY EXPENSES**	
Household Gross Pay	$	Car (loan, gas, repairs)	$
Take Home Pay	$	House (mortgage, rent)	$
Child Support	$	Child Care	$

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Supplemental Security Income (SSI)	$	Other	$
Other	$		

Additional Financial Comments (If Any)

GRANT/SCHOLARSHIP SPECIFICS

Please list the provider that you intend to utilize with the funds received from the SPEECH PATHways Foundation for speech and language services

Provider Name: _____

Provider Address: _____

_____

Provider Phone: _____

Provider Web Site: _____

Has this provider agreed to provide services for your child?_____

What is the cost of requested service?_____

Why are you choosing this provider for services (include specifics such as necessary specialty areas, unique programs, etc.)

_____

_____

_____

_____

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Request for More Information, Disclaimer and Signature

After you read the disclaimer, please sign below and mail the application along with the additional information required.

Acknowledgments & Waiver of Liability Agreement

Submission of a completed grant application does not guarantee SPEECH PATHways Foundation will approve the request for funds. If a grant is approved for disbursement for the child's benefit, the grant will be limited to the amount specified by the Board of Directors.

I hereby certify that I am the parent or legal guardian of the child with the legal right to execute and consent to this application and to the best of my knowledge the information provided is true and correct.

I understand that if I have misrepresented any of this information, this grant may immediately and retroactively become invalid.

I consent to the release of any medical records to the Foundation Board of Directors for their review of the request. In addition, if a grant is awarded to me for the benefit of my child, I authorize the SPEECH PATHways Foundation to utilize a photo of my child and the story of my child for the purpose of informing others about the SPEECH PATHways Foundation.

I do hereby fully release and discharge the SPEECH PATHways Foundation or Community Foundation of Carroll County and its Advisory Board and Executive Board members from any and all claims and/or liability resulting from injury, damage or losses which I or my child may have or accrue from the use of funds distributed by the SPEECH PATHways Foundation for the treatment of my child. I agree to indemnify and hold harmless the SPEECH PATHways Foundation and its Advisory Board and Executive Board members from the same. I agree to waive and relinquish and all claims I or my child may have against the SPEECH PATHways Foundation and its officials as a result of the use of funds from the SPEECH PATHways Foundation for treatment of my child.

I understand that the SPEECH PATHways Foundation makes no representations as to the adequacy of treatment provided by the use of the funds requested and I fully release the SPEECH PATHways Foundation from any and all liability.

☐ Check the box if you do not agree to the use of your photo(s) and/or story.

Signed by*: (First Name, Last Name) _____ **Date:** _____

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PARENT/FAMILY SERVICE COMMITMENT

Each parent/family that receives a grant/scholarship for their child is asked to donate a small portion of service time to the SPEECH PATHways Foundation (2-10 hours). This donation can be in the form of helping out at fundraisers, assisting with community outreach or other agreeable functions determined by the SPEECH PATHways Foundation Advisory Board. If a family does not wish to volunteer services, then you will be responsible for a minimal portion of fees for service.

I, _____ understand that if my child _____is accepted for a grant and/or scholarship that I will be required to donate a small portion of my time to the SPEECH PATHways Foundation. By signing you are hereby agreeing to the terms of this agreement.

_____ _____
Child's Name Parent/Guardian Name (please print)

_____ _____
Date Parent/Guardian Name (signature)

ADDITIONAL INFORMATION REQUIRED

- A recent letter from the child's physician explaining medical necessity, and/or a letter from a health care professional explaining how the applicant would benefit from the services you are requesting.
- Proof of all income for the past 2 years (copies of entire tax return state & federal) must be included.
- Any other documentation pertaining to the child or nature of the request.
- Proof of extenuating circumstances may be requested by the Board prior to receiving a grant and/or scholarship.

I certify that the above information is true. I will notify the **SPEECH PATHways Foundation** of any changes to the above information.

_____ _____
Child's Name Parent/Guardian Name (please print)

_____ _____
Date Parent/Guardian Name (signature)

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HIPPA Authorization Form

COMPLETE SECTION A:

A. Identification

This document authorizes the use and/or disclosure of confidential protected health information about the following person(s):
Name: _____ Social Security Number: _____

Address:_____
Date of Birth: _____ Daytime Phone Number: ( ) _____

Name(s) of whom information may be used and/or disclosed:
_____

B. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the member(s) listed in Section A to the individual or company identified in Section B.1. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information, claims records, claims status, and patient management records, according to my directions.

CHECK ALL THAT APPLY IN SECTION B.1:

B.1. I authorize the disclosure and obtaining of information to/from:
___ SPEECH PATHways Foundation Advisory Board Review Committee
___ Human Resources: _____ ___ My Medical Plan (Name): _____
___ My Dental Plan (Name):_____ ___ My Prescription Plan (Name):_____
___ My Physician/Provider (Name):_____ ___Other (Name or describe):_____
___ My Legal/Personal Representative (Name or describe): _____

CHECK ALL THAT APPLY IN SECTION B. 2:	**CHECK ALL THAT APPLY IN SECTION B.3:**
B.2. I authorize the disclosure and/or use of the following information: _____(a) any information related to the acquisition of the medical grant _____(b) my entire medical record _____(c) my enrollment, eligibility and premium payment records _____(d) Other (describe information in detail): _____ _____	B.3. I authorize the disclosure and/or use for the following reason(s): _____(a) for review and appeal of medical grant _____(b) for my own purposes _____(c) Other(describe purposes in detail): _____ _____ _____ _____ _____

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READ SECTION C:

C. Right to Revoke:

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: SPEECH PATHways Foundation.

YOU AND A WITNESS MUST SIGN IN SECTION D:

D. Authorization and Signature: I authorize the release of my confidential protected health information as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I,_____, have read the contents of this Authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____ Your Signature / Legal Representative Date	_____ _____ Signature of Witness Date

FOR A LEGALLY APPOINTED REPRESENTATIVE:

1. If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the member.
2. Please provide a copy of this form to your authorized representative so that they will be able to establish the validity of their request for your protected health information.

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