Application Checklist

- [ ] All Sheets in Application filled Completely
- [ ] All Sheets Signed and Dated
- [ ] Copy of Insurance Cards if Applicable
- [ ] Copy of Last Two (2) Paycheck Stubs
- [ ] Copy of Last Two Statements from other Income Sources
- [ ] Copy of Rent/Mortgage Statement
- [ ] Copy of All Applicable Utility Statements
- [ ] Copy of Latest Car Loan Statement
- [ ] Copy of Latest Car Insurance Statement
- [ ] Proof of all Other Expenses (Minus Food)
- [ ] Must Include TS Diagnosis Information
- [ ] Must Include Comorbid History
- [ ] Individual's Story
- [ ] Information on Why Individual wants to try CBIT
- [ ] Information on Why Individual feels they are a Good CBIT Candidate

NOTES :

Enter "N/A" for Non-Applicable Information

Sign & Date All Sheets. Please feel free to attach more paper if needed.

Have you applied or received financial aid from The Tourette CBIT Foundation or any other program before? ☐ Yes ☐ No

If yes, please list name and date of organization: _____

_____

How did you hear about The Tourette CBIT Foundation? _____

_____

On separate sheets, please include the individual's story and why they feel they are a good candidate for CBIT. Applications will not be accepted without this information.

The recognition of The Tourette CBIT Foundation has created many requests for financial aid. As you know, our foundation provides an important function in our community, and our goal is to continue assisting families. In order for us to continue to provide funds to families in need, we need to raise money through our annual fundraisers and donations.

Patient or Legally Authorized Individual Signature **Date**

Printed Name of Person Signing Release **Relationship**

THE TOURETTE CBIT FOUNDATION

APPLICATION FOR SUPPORT

PERSONAL INFORMATION

Full Name :

Date Of Birth : / / Gender :

Address :

Address :

Phone Number : E-Mail :

GUARDIAN/CARE-TAKER INFORMATION

Full Name :

Date Of Birth : / / Gender :

Address :

Address :

Phone Number : E-Mail :

PHYSICIAN/NEUROLOGIST INFORMATION

Full Name :

Address :

Address :

Phone Number : E-Mail :

Full Name :

Address :

Address :

Phone Number : E-Mail :

Patient or Legally Authorized Individual Signature Date

TOURETTE SYNDROME AND COMORBID HISTORY

Date of Diagnosis : _____ Age of Diagnosis: _____

Diagnosed By : _____

Other Comorbid Conditions : _____ Date of Diagnosis: _____

_____ _____

_____ _____

_____ _____

_____ _____

Treatments Sought for Comorbid Conditions and Results : _____

_____

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Patient or Legally Authorized Individual Signature Date

CBIT THERAPIST

Full Name :

Address :

Address :

Phone Number : E-Mail :

CBIT Cost :

INSURANCE

Insurance Coverage : ☐ Yes ☐ No

If yes, Carrier :

Family Deductible :

Individual Deductible :

Does Insurance Cover CBIT? : ☐ Yes ☐ No

If yes, at what Percentage :

Does CBIT Therapist Accept Insurance? : ☐ Yes ☐ No

If you clicked to yes to all three questions, you MUST include a statement showing current deductible progress.

EMPLOYMENT INFORMATION Guardian One

Employer :

Position :

Dates of Employment : To: / / From: / /

Reason for Leaving :

Address :

Phone Number : E-Mail:

Rate : ☐ Hourly ☐ Salary ☐ Other

Paid : ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other

Patient or Legally Authorized Individual Signature **Date**

EMPLOYMENT INFORMATION CONTINUED

Employer :

Position :

Dates of Employment : To: __/__/__ From: __/__/__

Reason for Leaving :

Address :

Phone Number : E-Mail:

Rate : ☐ Hourly ☐ Salary ☐ Other

Paid : ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other

Employer :

Position :

Dates of Employment : To: __/__/__ From: __/__/__

Reason for Leaving :

Address :

Phone Number : E-Mail:

Rate : ☐ Hourly ☐ Salary ☐ Other

Paid : ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other

Patient or Legally Authorized Individual Signature **Date**

EMPLOYMENT INFORMATION Guardian Two

Employer :

Position :

Dates of Employment : To: __/__/__ From: __/__/__

Reason for Leaving :

Address :

Phone Number : E-Mail:

Rate : ☐ Hourly ☐ Salary ☐ Other

Paid : ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other

Employer :

Position :

Dates of Employment : To: __/__/__ From: __/__/__

Reason for Leaving :

Address :

Phone Number : E-Mail:

Rate : ☐ Hourly ☐ Salary ☐ Other

Paid : ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other

Patient or Legally Authorized Individual Signature **Date**

EMPLOYMENT INFORMATION CONTINUED

Employer :

Position :

Dates of Employment : To: __/__/__ From: __/__/__

Reason for Leaving : _____

Address : _____

Phone Number : _____ E-Mail: _____

Rate : ☐ Hourly ☐ Salary ☐ Other _____

Paid : ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other _____

Patient or Legally Authorized Individual Signature **Date**

FINANCES

Please share with us some information below regarding your financial situation. We are happy to help all types of income ranges but like to have a good picture of where you stand financially in order to help the board understand your entire situation. Please print or type clearly.

Unemployment	:	**Social Security**	:
Other Income Source	:	**Disability**	:
Rent/Mortgage:	:	**Net Income Total**	:
Utilities	:	**Credit Card**	:
Phone	:	**Loans**	:
Internet	:	**Second Mortgage**	:
School Expenses	:	**Medical Bills**	:
Food	:	**Other Expenses**	:
Gas	:		
Car	:		
Insurance	:		

Total :

Employment Income (Net) :

Patient or Legally Authorized Individual Signature **Date**

REFERENCES

Please provide three (3) references. The Tourette CBIT Foundation may use references to discuss and support your child's medical challenge, your need for assistance, and any other questions we may have.

Contact Name : _____ Home Number : _____

Relationship : _____ Mobile Number : _____

Contact Name : _____ Home Number : _____

Relationship : _____ Mobile Number : _____

Contact Name : _____ Home Number : _____

Relationship : _____ Mobile Number : _____

DISCLOSURES

My signature certifies that the information contained in this application is true and correct. I consent to release by my health care providers my child's medical information pertaining to the patient assistance program to be used for the program authorization process. I authorize The Tourette CBIT Foundation to use the information on this application to process the request for financial aid and further authorize the use of my social security number for identification and record keeping purposes. I understand The Tourette CBIT Foundation reserves the right at any time, without notice, to modify or discontinue this program and its eligibility criteria.

Patient or Legally Authorized Individual Signature **Date**

Printed Name of Person Signing Release **Relationship**

I grant permission for your clinic/facility to release financial information to The Tourette CBIT Foundation for the specific procedure, admission, or medical treatment as outlined above. I grant permission for a representative from The Tourette CBIT Foundation to discuss with your clinic/facility the CBIT treatment as outlined above and the resulting charges. I release The Tourette CBIT Foundation, its board members and volunteers, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent authorized indicated and authorized herein. I understand that I may revoke this authorization at any time.

Patient or Legally Authorized Individual Signature **Date**

Printed Name of Person Signing Release **Relationship**