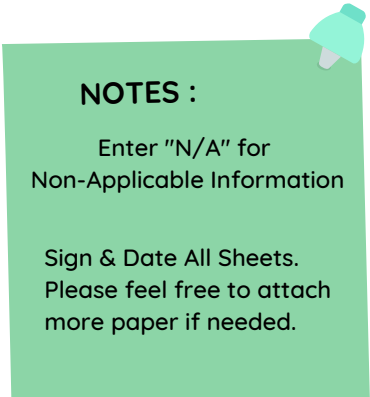


Application Checklist

- 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

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 : _____

Patient or Legally Authorized Individual Signature

Date

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