TURNING WHEELS

PART I. Child/Family Information

Child's Name: ___________________________________

Child's Date of Birth: ____________

Child's Gender: ____________

Home Address: ____

City:_________________________ State:_______ Zip Code:_______________

First Parent/Caregiver Name: _______________________________________

Phone #:____________________________

E-Mail:____________________________________

Relationship to child: ___________________

Employed: Yes / No

Second Parent/Caregiver Name: _____________________________________

Phone #:____________________________

E-Mail:____________________________________

Relationship to child: ___________________

Employed: Yes / No

Current Total Household Annual Income: **(Total household income may not exceed $100,000)**

- o Under $30,000
- o $30,000-$49,999
- o $50,000 - $74,999
- o $75,000 - $99,999
- o >$100,000

(Turning Wheels Foundation might request documentation to verify income)**

PART II. How will the grant be used for?

1. Ongoing Therapy:
   a. Speech Therapy ______ # times a week at $_________ per session.
   b. Occupational Therapy ______ # times a week at $_________ per session.
   c. Physical Therapy ______ # times a week at $_________ per session.
   d. ABA ______ # times a week at $_________ per session.
   e. Other (describe) ____
   ____

2. Therapy Evaluation:
   a. Speech Therapy at $ ______ per evaluation
   b. Occupational Therapy at $ ______ per evaluation
   c. Physical Therapy at $ ______ per evaluation
   d. ABA at $ ______ per evaluation
   e. Other Evaluation (describe) ____
   ____

3. Camp or workshop:

   a. Name of camp/workshop: ____

   b. Tell about the camp: ____

   c. Address / phone# / website: ____

   ____

   d. Dates: ____________ to ____________

   e. Fee: $_______________

4. Equipment:

   a. Description: ____

   b. Where to buy: ____

   c. Cost: ____

PART III. Applicant's Story

Please tell about the child and family telling how a grant could be helpful. Please attach any important information to your application.

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PART IV. Current Resources

1. Is the child currently receiving therapy services? Yes / No

If yes, please describe these services ____

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2. Does the child have funding from other sources to help with therapy needs, such as grants, scholarships, etc.? Yes / No

If yes, please share details:

$ _____________ Source of Support: _________________________ Expiration:________

$ _____________ Source of Support: _________________________ Expiration: ________

Other:

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3. Are multiple children in the family receiving therapy or medical services? Yes / No

If yes, describe: ____

____

PART V. Insurance

1. Does the child have Medicaid? Yes / No

2. Is the child covered by insurance for the requested services? (select one of below)
   - Yes, the child has insurance coverage for this therapy. Please include copies of the insurance forms that shows:

     $______________ Annual deductible per individual

     #______________ Annual number of therapy sessions allowed

     $______________ Coinsurance or copay

   - No, the child does not have insurance that covers these services. Please include insurance company information that shows the lack of coverage.

     (If you are unsure about your medical benefits please call your provider to understand coverage for therapy and the above financial information.)

PART VI. Provider

If you know the provider who will provide the services, please provide their details below.

Provider Name: ____

Provider Address: ____

Provider Phone Number: ____

Provider Email Address: ____

Services Provided: ____

Is this provider an in-network provider for your insurance? Yes / No

If no, please provide reason for choosing out-of-network provider: ________________

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For multiple service providers, please provide name and address details on separate sheet.

COMPLETED APPLICATIONS SHOULD BE SUBMITTED TO APPLY@TURNINGWHEELSFOUNDATION.ORG OR CAN BE MAILED TO:

TURNING WHEELS FOUNDATION
225 W. ROOSEVELT RD.
WHEATON, IL 60187