Kya's Krusade Financial Assistance Program
Additional Therapy Session Application

http://www.kyaskrusade.org

Application #____________________
Date Received __________________
(To be completed by Kya's Krusade)

Child's Information

Name _________________________ Birth date ________ Age ________ Gender ______

Physical Disability _________________________________ Age at Diagnosis _________

Primary Health Care Coverage (check all that apply):

_____ Insurance _____ Medicaid Other:_______________________________

Parent/Legal Guardian's Name(s)____

Number of Family Members ______ Family Members contributing to Household Income ______

Annual Household Income

___ less than $25,000 ___ $25,000 - $40,000 ___ $40,000-$60,0000 ___ $60,000 – $90,000 ___ $90,000 +

Applicant's Information

Name _____________________________ Relationship to Child ____________________________

Address _____________________________ E-mail Address _________________________________

____

Day Phone Number ____________________ Evening Phone Number _______________

Notification (Parent's) Address ____

____

Pediatrician or Physician Information

Name ______________________________ Medical Practice Name ___________________________

Address ____________________________ Phone Number ___________________________________

____________________________ Fax Number ___________________________________

E-mail and/or Website Address ____

Physical or Occupational Therapist Information

Name ____________________________ Clinic/Rehab Facility Name ________________________

Address __________________________ Phone Number ___________________________________

__________________________ Fax Number ___________________________________

E-mail/Website Address ____

Frequency of therapy sessions attended _______ times per ____ week ____ month ____ year

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Additional Therapy Information

Type of Therapy Requested ____ Physical ____ Occupational ____ Hippotherapy ____ Other: _________

Description of Therapeutic Activities ____

Goals that the additional sessions will help my child to achieve:

My child has engaged in this type of therapy before _____ Yes _____ No

My child is currently or has been a patient of this therapist within the last 12 months _____ Yes _____No

Cost of each session $ ______________________

Number of sessions requested ________________

Amount of Assistance Requested $ ____________

- **Please submit verification of the cost for each therapy session in the form of a signed letter on company letterhead by the therapist or facility through which the services would be obtained.**

Therapist Information

Name ___________________________ Clinic/Rehab Facility Name _______________________

Address _________________________ Phone Number _________________________________

_________________________ Fax Number _________________________________

E-mail/Website Address ____

If you do not receive assistance this cycle, would you like your application to be considered during the next cycle? _____ Yes _____ No

Application Checklist: The Completed Application
Parental Consent and Liability Release Form
Physician Medical Diagnosis Verification Form
Physical/Occupational Therapist Reference Form
Insurance rejection and/or sessions covered Letter
Therapy Cost Verification Letter

Please send all completed, signed original copies of the application materials to:

Kya's Krusade
947 E. Johnstown Rd., Ste. 143
Gahanna, Ohio 43230

I certify that all information provided is accurate and complete. I have the authority to submit this application on behalf of this child as her/his parent or legal guardian or with the permission of her /his parent or legal guardian.

______________________________________ ______________________________________
Print Name **Date** **Signature** **Date**

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Diagnosis Verification Form

This form must be completed and submitted by the Child's current Pediatrician or Physician.

Child's Name ____

Description of Therapy Services Requested ____

Application Submission Deadline ______/ ______/_______

Physician's Name ____

Specialty ______________________________ **Physician's ME Number** ___________________________

State(s) in which Physician is licensed to practice ____

Name of Practice ____

Physician's Office Address ____

____

Phone Number ___________________________ **Fax Number** ______________________________

As a physician of _________________________________, I verify the following concerning this child (please check all that apply):

_____ (S)he is one of my current patients (has been seen by me during the past 12 months)

_____ Has a diagnosis of ____.

_____ Was born on ______/ ______/_______.

_____ Was diagnosed at the age of _________ with this condition.

_____ In my professional opinion, the child could benefit from the additional therapeutic services.

Additional Comments:

I have been informed of the applicant's intent to apply for Financial Assistance from Kya's Krusade for the purpose of participating in additional therapy sessions. I understand that my office will be contacted to verify that I have sent and signed this form as part of the application process.

___________________________________ ______________________________________

Physician's Name **Date** **Physician's Signature** **Date**

Physical or Occupational Therapist Reference Form

Kya's Krusade
947 E. Johnstown Rd., Ste. 143 · Gahanna, Ohio 43230

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Physical/Occupational Therapist Reference Form
This form must be completed and submitted by the Child's current Physical or Occupational Therapist.

Child's Name ____

Description of Therapy Requested ____

Application Deadline ______/ ______/_______

Therapist's Name _________________________ **License Number** ________________________

Professional Therapy Designation ____ **Physical** _____ **Occupational** _____ **Other:** ________

Clinic or Rehabilitation Center Name ____

Address _______________________________ **E-mail** _________________________________

____

Phone number __________________________**Fax Number** ____________________________

As a Physical/Occupational Therapist of _________________________________, I am able to verify the following concerning this child (please check all that apply):

_____ (S) he is one of my current patients (has been seen by me during the past 12 months)

_____ Has a diagnosis of ____.

_____ Was born on ______/ ______/_______.

_____ Was diagnosed at the age of _________ with this condition.

_____ In my professional opinion, the child could benefit from the additional therapeutic services.

_____ Attends _____ therapy sessions per _____week _____ month _____ year

Additional Comments:

I have been informed of the applicant's intent to apply for Financial Assistance from Kya's Krusade for the purpose of participating in additional therapy sessions. I understand that my office will be contacted to verify that I have sent and signed this form as part of the application process.

___________________________________ ______________________________________

Therapist's Name **Date** **Therapist's Signature** **Date**

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Parental Consent and Release from Liability

I, the undersigned, am the parent or legal guardian of _______________________ (child's name).

- I hereby give my permission for the applicant ________________________ (applicant's name) to submit a Kya's Krusade Financial Assistance Program Equipment Application on behalf of my child.
- I certify that I have thoroughly reviewed the application guidelines and the application prior to its submission and that all information provided is accurate and complete.
- I grant Kya's Krusade associates permission to contact my child's Physician and Physical or Occupational Therapist for the purpose of verifying the Diagnosis Verification Form and Therapist Reference Form.
- The stated applicant, not Kya's Krusade, is liable for any fraudulent actions or activities associated with the submission and resulting processing of this application.
- I understand that Kya's Krusade does not provide physical therapy, occupational therapy or hippotherapy services, referrals or advice. Kya's Krusade, its associates, agents and employees are not liable for any claims, judgments or punitive damages associated with the receipt, quality of care or associated injuries incurred during and/or from the child's participation in therapeutic activities and sessions purchased with funds distributed through the Financial Assistance Program.

___________________________________ ______________________________________

Parent's Name **Date** **Parent's Signature** **Date**

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