



PO Box 1345
 Roswell, GA 30077
www.mylesapart.org

All applications due by April 30, 2009
 Mail to address above OR
 Email to applications@mylesapart.org

2009 SUMMER PROGRAM SCHOLARSHIP APPLICATION

CHILD/APPLICANT INFORMATION									
Last Name:		First:		M.I.:		Date of Birth:			
Street Address:						Apartment/Unit #:			
City:			State:			ZIP:			
Phone:			County:						
Child's Diagnosis:					School Attending:				
Therapy services Child receives in school and/or private: (including Frequency)									
<input type="checkbox"/> Occupational Therapy			<input type="checkbox"/> Physical Therapy			<input type="checkbox"/> Speech Therapy			
Frequency:	_____		Frequency:	_____		Frequency:	_____		
FAMILY									
Father's Name:						Date of Birth:			
Street Address:						Apartment/Unit #:			
City:			State:			ZIP:			
Phone:			County:						
Email Address:									
Employer:					Telephone:				
Employer Address:									
Mother's Name:						Date of Birth:			
Street Address:						Apartment/Unit #:			
City:			State:			ZIP:			
Phone:			County:						
Email Address:									
Employer:					Telephone:				
Employer Address:									

SIBLINGS

Name:		Age:		School Attending:	
Does this child receive therapy?		<input type="checkbox"/> Yes Frequency: _____ <input type="checkbox"/> No			
Name:		Age:		School Attending:	
Does this child receive therapy?		<input type="checkbox"/> Yes Frequency: _____ <input type="checkbox"/> No			
Name:		Age:		School Attending:	
Does this child receive therapy?		<input type="checkbox"/> Yes Frequency: _____ <input type="checkbox"/> No			

INSURANCE

Carrier Name:		Phone:	
Mailing Address:			
City:		State/Zip:	
Employee's Name:		Insured's DOB:	
ID#:		Group#:	
Employer/Group Name:			

MEDICAID

If your child has Medicaid, please complete the following information:

Medicaid plan type:	<input type="checkbox"/> Katie Beckett	<input type="checkbox"/> CMO	<input type="checkbox"/> SSI	<input type="checkbox"/> Other _____
Plan ID#:	_____			

THERAPY

Facility(ies) where child is currently receiving therapy:			
How long has your child been receiving therapy at this/these facility(ies)?			
Address:			
City:		State/Zip:	
County:			
Owner's/Manager's Name:		Telephone:	

Where has your child received therapy in the past?

All information from this point forward should NOT include your child's name or any identifying information.

In the section for a therapist or doctor to fill out, again, please do not have that person sign their name or use your child's name.

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application leads to a scholarship, I understand that false or misleading information in my application may result in my forfeiture of the funding.

How did you hear about Myles-A-Part's summer scholarship program?:

Signature:		Date:	
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SERVICES CURRENTLY RECEIVING	FREQUENCY/WEEK	<u>YOUR</u> OUT OF POCKET COST/SESSION	DOES INSURANCE COVER THIS SERVICE?	DOES MEDICAID COVER THIS SERVICE?
Occupational Therapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physical Therapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Speech Therapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Group Therapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aquatic Therapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Music Therapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hippotherapy		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
ABA		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER: _____		\$	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If your child is NOT currently receiving therapy, please explain why: _____

FINANCIAL INFORMATION

ASSETS		LIABILITIES	
Checking Account:	\$	Monthly House Payment/Rent:	\$
Savings Account:	\$	Other Monthly Bills/Loans:	\$
Real Estate:	\$	Monthly Utilities:	\$
Current Equity in your home:	\$	Physician/Agency Fees (YOUR monthly cost):	\$
Automobiles:	\$	Monthly Automobile Expenses:	\$
Personal Property:	\$	Medical Bills Due (YOUR monthly cost):	\$
Other Assets:	\$	Monthly Insurance:	\$
TOTAL ASSETS:	\$	Medication (YOUR monthly cost):	\$
		Other: _____	\$
		TOTAL LIABILITIES:	\$

COMBINED SOURCES OF INCOME – PLEASE NOTE: PREVIOUS YEAR'S IRS RETURN MUST BE ATTACHED

INCOME TYPE	MONTHLY	ANNUAL
Salary:	\$	\$
Bonuses and Commissions:	\$	\$
Alimony/Child Support:	\$	\$
Real Estate Income:	\$	\$
All Other Income*:	\$	\$
TOTAL INCOME:	\$	\$

*ALL OTHER INCOME is including grants, social security, Medicaid, other funding sources, etc.

MAP USE ONLY: DOB: _____ DX: _____
 Applicant#: _____

PLEASE NOTE: DO NOT USE ANY NAMES OF YOUR CHILD (USE HE/SHE OR 'THIS CHILD') OR THERAPIST'S NAME IN THIS SECTION

For a treating therapist or doctor to fill out:

How would this child benefit from receiving this scholarship?

For a parent to fill out:

How would your child benefit from this scholarship?

Medical history:

Current functional status:

All information included in this application is confidential and for use only during consideration for the summer scholarship process. Please keep a copy for your records.

MAP USE ONLY: DOB: _____ DX: _____
Applicant#: _____