



The Children's TherAplay Foundation, Inc.

2026 Scholarship Application

Submission Deadline

Please return the completed application to the front office **by 5:00 PM on Friday, June 26, 2026.**

(A separate application is required for each child)

Date of Application: _____

Important Notice:

This application will **NOT** be reviewed without **ALL** required documentation.

I understand that the scholarship is not effective until approved, and that during the interim, the full fee-for-service amount will be the responsibility of the patient.

Patient Information

Patient Name: _____

Date of Birth: _____

Type of services currently being received:

Physical Therapy Occupational Therapy Speech Therapy

Household Demographics

- **Annual Household Income:** \$ _____
- **Number of Full-Time Residents in Household:** _____
- **Number of School-Age Children:** _____
- **Number of Children in Childcare:** _____

Parent/Guardian Information

Parent/Guardian 1

- Name: _____
- Home Address: _____
- City, State, ZIP: _____
- County: _____
- Phone (Home): _____
- Phone (Work): _____
- Cell: _____
- Email: _____

Parent/Guardian 2

- Name: _____
- Home Address: _____
- City, State, ZIP: _____
- County: _____
- Phone (Home): _____
- Phone (Work): _____
- Cell: _____
- Email: _____

Insurance Information

Insurance Provider 1

- Insurance Company: _____
- Policy/Group #: _____
- Address: _____
- City, State, ZIP: _____
- Telephone: _____
- Insured's Name: _____
- SSN #: _____
- Date of Birth: _____
- Relationship to Client: _____

Insurance Provider 2

- Insurance Company: _____
- Policy/Group #: _____
- Address: _____

Scholarship Billing Policies

The Children's TherAplay Foundation, Inc.

As a recipient of the Scholarship Program, I understand the following:

- The average fee for physical, occupational, and speech therapy services ranges from **\$150.00–\$280.00 per session**. The Children's TherAplay Foundation, Inc. Scholarship Program is made possible through a generous contribution from **Indianapolis Indians Charities**.
- Once my Scholarship Application has been completed and processed, a determination will be made regarding my out-of-pocket payment for each date of service.
 1. I understand that I may be responsible for my **co-payment or co-insurance amount** on every date of service.
 2. I understand that I am responsible for my **insurance contractual payment amount** while meeting my patient deductible.
(Note: If you need assistance obtaining this information, it can be found on your insurance Explanation of Benefits [EOB].)
- Applicants will be notified of the **final determination by email within 30 days** of receipt of their application.

Acknowledgment and Signature

I have received, read, understand, and agree to comply with The Children's TherAplay Foundation, Inc. Scholarship Policies listed above.

Signature: _____

Date: _____

One copy is for your records. A second signed copy must be returned to The Children's TherAplay Foundation, Inc.

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Administrative Use Only

(Optional: This page can be used for internal notes, approval signatures, or processing details.)

Application Received By: _____

Date Received: _____

Reviewed By: _____

Determination: Approved Denied Pending

Notes:

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