



**Children's TherAplay**  
The Children's TherAplay Foundation, Inc.

# 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, September 25, 2026.**

*(A separate application is required for each child)*

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**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.

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## Patient Information

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Type of services currently being received:**

☐ Physical Therapy    ☐ Occupational Therapy    ☐ Speech Therapy

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## 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: \_\_\_\_\_

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# 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: \_\_\_\_\_

- **City, State, ZIP:** \_\_\_\_\_
- **Telephone:** \_\_\_\_\_
- **Insured's Name:** \_\_\_\_\_
- **SSN #:** \_\_\_\_\_
- **Date of Birth:** \_\_\_\_\_
- **Relationship to Client:** \_\_\_\_\_

## Narrative Question

Please explain why co-payments have become burdensome and potentially prohibitive to your continuation of care at The Children's TherAplay Foundation, Inc., and how assistance from the Scholarship Fund may help alleviate your family's financial barriers:

[illegible]

## Required Attachments

☐ I have included my most recent **Federal and State tax returns** (only the first and last pages are required).

**Important:** In the event of shared or joint custody, *all custodial parties* must attach copies of their most recent federal and state tax returns.

# 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 generous contributions from **dedicated donors**. 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.

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## 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:** \_\_\_\_\_

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

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*End of Page 3*

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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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