



DISABILITY NETWORK, INC.

Therapy Scholarship Application

Website: www.bridgedisability.org

Thank you for your interest in applying for a scholarship from Bridge Disability Network, Inc., a nonprofit 501(c)3 public charity.

The Board of Directors will review and provide scholarships to individuals in accordance with our guidelines and policies.

Applications are reviewed and scholarships are awarded on a quarterly basis. Deadline dates are February 1st, May 1st, August 1st, and November 1st. You will receive notification of the Board's decision within 60 days of the application deadline. Notification will be sent via email to the person nominating the applicant. Please use the Application Checklist on the following page to ensure your application is complete. Only complete applications will be considered. Scholarships are considered for children who are legal citizens or permanent residents of the United States ages birth through 22 years of age.

You may type information on this form and print it out and sign to send by mail, fax or an email attachment. Please submit your completed application and all supporting materials to Bridge Disability Network, Inc. by one of the methods below.

MAIL:

Bridge Disability Network
500 North Park Road
Hollywood, FL 33021
Attn: Scholarship Selection Committee

FAX: (305) 397-1755

EMAIL: bridgedisability@gmail.com

Application Checklist

The following items are required to be completed or submitted with your application. Incomplete applications will not be considered and you will not be notified if the application is incomplete.

You will only be considered for a scholarship for one therapy service per year. Please check only one box for type of therapy requesting. Respite care, medical equipment or AAC devices will be determined on a case-by-case basis.

☐ Scholarship for Medical Equipment or AAC device

☐ Scholarship for Respite Care

☐ Speech Therapy Scholarship ☐ Yes, I have a current evaluation* ☐ No

* Current (within 6 months) speech and language evaluations and/or reports completed by a licensed and ASHA-certified speech and language pathologist. The evaluation should identify the applicant's communication disorder along with standardized assessments demonstrating the need for therapy.

☐ Physical Therapy Scholarship ☐ Yes, I have a current evaluation* ☐ No

* Current (within 6 months) Physical Therapy evaluation and/or report by a licensed Physical Therapist. The evaluation should contain physical handicap and standardized assessment demonstrating a need for therapy.

☐ Occupational Therapy Scholarship ☐ Yes, I have a current evaluation* ☐ No

* Current (within 6 months) Occupational Therapy evaluations and/or report by a licensed Occupational Therapist. The evaluation should contain physical handicap and standardized assessment demonstrating a need for therapy.

☐ Behavioral Therapy Scholarship ☐ Yes, My child has been diagnosed* ☐ No

*Diagnosis for Autism Spectrum Disorder either through the school system or neurologist report.

Evaluations/reports must be on professional letterhead and dated within 6 months of the date of application.

Completed up-to-date and signed school IEPs are acceptable. Treatment recommendations by a speech therapist, physical therapist, occupational therapist, psychologist or neurologist must be included. The IEP must be current for that school year.

II. Explanation letter from insurance provider stating number of therapy sessions allowed per calendar year and deductible. If this is not a covered service, you must provide the denial letter (or Explanation of Benefits page from manual). If you are applying for an AAC device, a copy of your Explanation of Benefits page is also required. If applying for something other than private therapy, please include a statement from a speech and language pathologist, physical therapist or occupational therapist on why this service/device is required to better the individual.

III. A copy of most recent IRS 1040 form- Please white out / delete all social security numbers. If you cannot provide a copy of a 1040, please contact us at bridgedisability@gmail.com before submitting your application.

IV. Contact information of the specific service provider facility and therapist (name, address, phone number, email) where applicant will be receiving treatment. Therapist must be informed that you are applying for a scholarship through their facility as Bridge Disability Network, Inc. often contacts the therapists.

If applying for a scholarship to be used for therapy, a formal quote of service must be included with application on provider's letterhead detailing cost per session and the name of the therapist who will be providing treatment.

If applying for a scholarship for an assistive technology device, a formal Augmentative and Alternative Communication (AAC) Evaluation conducted by an ASHA certified SLP must be included stating that different pieces of technology have been trialed and what you are requesting is the best fit for a means of communication. Bridge Disability Network, Inc. will not award grants for iPads; or for iPad software. If applying for materials/equipment, please include the following information: full name of device, price and descriptive information directly from the manufacturer's website, including web address.

Scholarship Application

Part I. Family History

Date: Applicant's Name:

Gender: Date of Birth:

Home Address:

Street:

City:

State: Zip Code: County:

Primary Number(s): Home: Mobile:

Family E-mail Address:

Parent/Guard Name: Relationship to Child:

Occupation: Name of Employer:

Parent/Guard Name: Relationship to Child:

Occupation: Name of Employer:

Primary Language Spoken in the Home:

Child's Primary Mode of Communication:

Diagnosis:

Grade level of Child (if applicable):

Name of Attending School or Treatment Facility:

Number of children living in the home:

Please select your current Annual Household Income:

☐ Under \$30,000 ☐ \$30,000 - \$49,999 ☐ \$50,000 - \$74,999 ☐ \$75,000 - \$100,000
☐ \$100,000 and up

Please include Copy of Recent IRS 1040 form included with application (White out / delete all social security numbers). If not included application will be considered incomplete.

* Are there photos enclosed in this application? ☐ Yes ☐ No
* Are there videos enclosed in this application? ☐ Yes ☐ No

*Photographs and videos are reviewed solely by the Board of Directors to understand the applicant's condition, and have no other influence on the scholarship decision. All photos/videos become property of Bridge Disability Network, Inc. and may be used for promotions/events. Personal information, other than first name, will not be distributed. Photographs and videos will not be returned.

Scholarship Application (continued)

Part II: Person Nominating the Applicant

☐ Check here if information is the same as Part I and proceed to Part III

Name:
Address:
City: State: Zip Code:
County:

Primary Phone Number: E-mail Address:
Place of Employment: Years Employed:

Part III: Professional Service Provider Information

Please note: It is the applicant's responsibility to identify a service provider. Therapy providers must be informed that an application is being submitted for a scholarship from Bridge Disability Network, Inc.

Name of Professional Service Provider with whom you would like to receive an evaluation and/or services:

Therapist Name:
Business Name:
Address:
Street:
City: State: Zip Code:
County:
Primary Phone Number:
E-mail Address:
Tax ID# or State License #:

The service provider has been informed of this scholarship application. (Required) If applicable, provide a copy of the last two statement bills from therapy provider on professional letterhead.

A formal quote of service is included on provider's letterhead; detailing cost per session and the name of the therapist the applicant will be working with.

Scholarship Application (continued)

Part IV: Specific Scholarship Request

Please state what the scholarship will be used for and why it is needed. If you are applying for a camp/workshop or respite care include all information about the price, date(s) and objectives. (Please provide this information in the space below or on a separate piece of paper submitted with the application in 200 words or less.)

Part V: How Did You Hear About Bridge Disability Network, Inc.?

Part VI: Applicant's Story

Please provide relevant information about the child or adult as it relates to communication disorders or physical disabilities. The information can include, but is not limited to, how treatment will improve the applicant's daily life, how treatment will help the long-term outlook of the applicant and/or how the treatment will affect the family's quality of life. Also consider providing information about the personality traits, prognosis in therapy, treatment history and treatment goals of the applicant. Please tell us why this is important to everyone involved. (Please provide this information in the space below or on a separate piece of paper submitted with the application in 500 words or less.)

Scholarship Application (continued)

Part VII: Additional Assistance

Is the applicant currently receiving private speech, occupational or physical therapy services?

Speech/Language Therapy ☐ Yes ☐ No

Where:

How often:

What type of setting (individual/group/consultation):

Occupational Therapy ☐ Yes ☐ No

Where:

How often:

What type of setting (individual/group/consultation):

Physical Therapy ☐ Yes ☐ No

Where:

How often:

What type of setting (individual/group/consultation):

Behavioral Therapy ☐ Yes ☐ No

Where:

How often:

What type of setting (individual/group/consultation):

2. Does the applicant currently receive therapy through the school system?

☐ Yes ☐ No

-If yes, how often, and what type of setting (individual/group/in-class/consultation).

-If no and over the age of 3.0 years, please explain rationale for not receiving school-based therapy.

3. Does the applicant receive any other funding from other sources including any other grants, family support, scholarships, etc?

☐ Yes ☐ No

-If yes, explain past and present support (include amount of financial support and will support will expire; along with organization or family member that provided assistance):

4. Has the applicant applied for Bridge Disability Network, Inc. scholarship in the past?

☐ Yes ☐ No

-If yes, please summarize:

Part VIII: Insurance

1. Is the applicant covered under insurance for the requested services?

☐ Yes ☐ No

- Please provide explanation letter from insurance provider stating number of speech, occupational or physical therapy sessions allowed per calendar year and deductible. If this is not a covered service, you must provide the denial letter (or Explanation of Benefits page from manual). If you are applying for an AAC device, a copy of your Explanation of Benefits page is also required.

Privacy and Terms of Use

Bridge Disability Network, Inc. respects your rights of privacy. Your privacy is important to us. The information received by the Bridge Disability Network, Inc. will be used solely to determine awarding a charitable scholarship. We will not sell your e-mail address to anyone or share your personal information with anyone other than a representative of the public charity in compliance with HIPPA regulations. Please be advised that your photos may be used for promotional purposes. Although the company has taken reasonable precautions to ensure no viruses are present in this email, the company cannot accept responsibility for any loss or damage arising from the use of this e-mail or attachments. We use personal information to pursue the mission of the Bridge Disability Network, Inc. All information shall be used for a lawful purpose. You agree that all information provided to the Bridge Disability Network, Inc. is truthful and accurate. Any attempt to provide false information will result in the dismissal of the application. The applicant will be removed from consideration of any grants from Bridge Disability Network, Inc. in the future. If a grant is awarded based on false information or if grant is not used as designated, it could result in legal action against the person nominating the individual or the applicant. Submission of any personal information constitutes an agreement to the Bridge Disability Network, Inc.

PRIVACY AND TERMS OF USE POLICY

YOU AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS THE BRIDGE DISABILITY NETWORK, INC., FROM AND AGAINST ANY AND ALL LOSSES, DAMAGE, LIABILITY AND COST OF EVERY NATURE INCURRED BY THEM IN CONNECTION WITH ANY CLAIM, DAMAGE OR LOSS RELATED TO OR ARISING OUT OF ANY ASSISTANCE OR SERVICES PROVIDED, ANY ALLEGED BREACH OR BREACH BY YOU OF THESE TERMS. YOU AGREE TO COOPERATE FULLY IN THE DEFENSE OF ANY OF THE FOREGOING. FROM TIME TO TIME THE BRIDGE DISABILITY NETWORK, INC. MAY AMEND THE PRIVACY AND TERMS OF USE POLICY, ALL AMENDMENTS SHALL BE EFFECTIVELY IMMEDIATELY. BRIDGE DISABILITY NETWORK, INC. DOES NOT DISCRIMINATE AGAINST RACE, GENDER OR RELIGION.

WE DO NOT GUARANTEE THE SECURITY OF PERSONAL INFORMATION OR OTHER INFORMATION IN ANY FORM. PLEASE DO NOT PROVIDE OR ALLOW OTHERS TO PROVIDE PERSONAL INFORMATION ABOUT ANYONE UNLESS YOU, ON YOUR OWN BEHALF AND ON BEHALF OF ANYONE WHO'S INFORMATION YOU PROVIDE, ARE AUTHORIZED TO DO SO.

TO THE FULL EXTENT ALLOWED BY LAW, YOU AGREE THAT THE BRIDGE DISABILITY NETWORK, INC. WILL NOT BE LIABLE TO YOU OR ANYONE ELSE FOR ANY SPECIAL, CONSEQUENTIAL, INCIDENTAL OR PUNITIVE DAMAGES, DAMAGES FOR LOST PROFITS, FOR LOSS OF PRIVACY OR SECURITY, FOR LOSS OF REPUTATION, FOR FAILURE TO MEET ANY DUTY (INCLUDING BUT NOT LIMITED TO THE DUTY OF GOOD FAITH OR LACK OF NEGLIGENCE OR OF WORKMANLIKE EFFORT), OR FOR ANY OTHER SIMILAR DAMAGES WHATSOEVER THAT ARISE OUT OF OR ARE RELATED TO ANY ASPECT OF THE APPLICATION AND INFORMATION DISCLOSED.

With my signature I understand that I agree to the Privacy and Terms and give Bridge Disability Network, Inc. permission to contact all related service providers as mentioned in the application.

Signature of Person Applying for Scholarship

Date: _____

Print Name of Person Applying for Scholarship

I verify that I am the above named person and the name I have provided is my own. I understand that false statements will immediately invalidate my application to Bridge Disability Network, Inc.

Signature of Parent/Legal Guardian

Date: _____

Print Name of Parent/Legal Guardian

I verify that I am the above named person and the name I have provided is my own.
I understand that false statements will immediately invalidate my application to Bridge Disability Network, Inc.