2011 Dupont Avenue S.
Minneapolis, MN 55405
(612) 584-9803 | ritecaremsp.org

# RiteCare® Grant Application

**(Official Use Only) Date Received_____ / Action Taken_____**

## SECTION I

**Date_____**

| Applicant Information (Child) | | | |
|---|---|---|---|
| | | | |
| **Last Name** | **First Name** | | **Middle** |
| | | | |
| **Home Address** | | **City** | **State / Zip Code** |
| | | | |
| **County** | **Home Phone Number** | **Sex** | **Birth date (MM/DD/YY)** |

| Father's Information | | |
|---|---|---|
| | | |
| **Last Name** | **First Name** | **Email Address** |
| | | |
| **Home Address (if different from child)** | **City** | **State / Zip Code** |
| | | |
| **Home Phone Number** | **Work Phone Number** | **Mobile Phone Number** |

| Mother's Information | | |
|---|---|---|
| | | |
| **Last Name** | **First Name** | **Email Address** |
| | | |
| **Home Address (if different from child)** | **City** | **State / Zip Code** |
| | | |
| **Home Phone Number** | **Work Phone Number** | **Mobile Phone Number** |

| Legal Guardian Information (if different from Mother / Father) | | |
|---|---|---|
| | | |
| **Last Name** | **First Name** | **Email Address** |
| | | |
| **Home Address (if different from child)** | **City** | **State / Zip Code** |
| | | |
| **Home Phone Number** | **Work Phone Number** | **Mobile Phone Number** |

## SECTION II

**Has your child been evaluated for speech/language concerns by a MN licensed speech/language clinician?** **YES / NO**

**If yes, give therapist name, location and date where evaluation took place:**
**(Please note RiteCare® grants do not cover cost of evaluation)**

| | |
|---|---|
| **Name** | **Date of Evaluation** |
| | |
| **Address** | **City / State** |

**Was therapy recommended for your child?** **YES / NO**

**Was your child eligible for speech services provided by a medical/private clinic?** **YES / NO**

**Was your child eligible for speech services provided by the school?** **YES / NO**

**Has treatment been received?** **YES / NO**

**If yes, give name of provider(s) and approximate dates of therapy**

| **Treatment Provider Information – Private** | | |
|---|---|---|
| | | |
| **Business Name** | | **Contact Person** |
| | | |
| **Address** | | |
| | | |
| **City** | **State / Zip Code** | **Telephone Number** |
| | | |
| **Dates of Treatment** | | |

| **Treatment Provider Information - School** | | |
|---|---|---|
| | | |
| **School Name** | | **Contact Person** |
| | | |
| **Address** | | |
| | | |
| **City** | **State / Zip Code** | **Telephone Number** |
| | | |
| **Dates of Treatment** | | |

**How did you learn about the RiteCare® of Minneapolis-St. Paul Grant Program?**

| |
|---|
| |

## SECTION III

**Does child have coverage for speech therapy under any medical insurance Plan, or State/Federal assistance?** **YES / NO**

**Parents/Legal Guardians Health Insurance Plan Information**

**Father's Insurance Company** **Name of Company**_____

**Policy Number**_____

**Mother's Insurance Company** **Name of Company**_____

**Policy Number**_____

**Are you responsible for a Deductible? (If yes, please provide amount)** **YES, $ _____ / NO**

**Are you responsible for a Co-Payment? (If yes, please provide amount)** **YES, $ _____ / NO**

**Is there a maximum to your Co-Payment? (If yes, please provide amount)** **YES, $_____ / NO**

## SECTION IV

**CONDITIONS OF APPLICATION**
***PARENTS OR LEGAL GUARDIAN – READ CAREFULLY***

**Application is hereby made for a grant from RiteCare® of Minneapolis-St. Paul, Inc. (2011 Dupont Avenue South, Minneapolis, MN 55405) for the above named child. Acceptance of the child for the grant is upon the conditions, and with the consents, in this application stated.**

**I hereby agree as follows:**

1) **The applicant is between the ages of three to seven (3 – 7) years.**
2) **An evaluation has been completed by a licensed speech/language therapist in Minnesota, and a need for speech therapy has been determined either medically, educationally, or both.**
3) **RiteCare® of Minneapolis-St. Paul is a secondary provider after all applicable insurance and government assistance.**
4) **The following therapy services are not covered by this grant:**
   a. **English as a Second Language**
   b. **Stuttering**
   c. **Deaf/Hard-of-hearing**
5) **The grant is for two years (commencing from the date of approval) and will not exceed $7,500.00. If a child graduates from services, due to progress, before the end of the second year, the grant will end at that time.**
6) **Payment will be made directly to your provider, upon receipt by RiteCare® of Minneapolis-St. Paul, Inc., of the following items: official bill from provider and list of services provided.**
7) **The undersigned acknowledges that he/she is selecting the therapist of his/her choice and the therapist has not been recommended by RiteCare® of Minneapolis-St. Paul, Inc. The undersigned acknowledges that he/she is selecting the therapist at his/her own risk. In addition the undersigned hereby releases and discharges RiteCare® of Minneapolis-St. Paul and the Scottish Rite from all liability and claims arising out of or related to the selection of any therapist or the provision of services by that therapist. This release is freely and voluntarily given.**

***RiteCare of Minneapolis-St. Paul does not review the credentials, expertise, or abilities of any therapist.***

***ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL***

**Remarks/comments:**

**Signature: _____ Date: _____**
**(Circle One: Father / Mother / Legal Guardian)**

**Signature: _____ Date: _____**
**(Circle One: Father / Mother / Legal Guardian)**

***Official Use Only***

**ACTION OF GRANT APPROVAL COMMITTEE**

**Date_____ Approved_____ Disapproved_____**

**Reason if disapproved_____**

**Signature_____**

**Please mail application to:**
**RiteCare® of Minneapolis-St. Paul, Inc**
**2011 Dupont Avenue South**
**Minneapolis, MN 55405**

**Or email to:**
**grants@ritecaremsp.org**