Creating a Future Full of Hope . . .
Helping Children Communicate

2011 Dupont Avenue South
Minneapolis, MN 55405
Tel: 612-584-9803
www.ritecaremsp.org

RiteCare® Grant Application

(Official Use Only) Date Received_____

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? **YES / NO**
If yes, give therapist name, location and date where evaluation took place:
(Please note RiteCare® grants do not cover cost of evaluation)

Was therapy recommended? **YES / NO**
If so, what therapy was recommended and why?

Has previous 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		**Is child currently in treatment? YES/NO**

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

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

SECTION III

Does child have coverage for speech therapy provided with State/Federal assistance? **YES / NO**

Parents/Legal Guardians Health Insurance Plan Information

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

Policy Number_____

Dates of policy period _____ **to** _____

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

Policy Number_____

Dates of policy period _____ **to** _____

Does policy provider benefits for child's diagnosis? Yes/No If yes, answer the following questions:

1. **What is the limit for number of annual speech therapy visits?** _____
2. **Provide policy deductible amounts: Individual $** _____ **Family $** _____
3. **Provide deductible if speech therapy provider you selected is "out-of-network": Individual $** _____ **Family $** _____
4. **Provide co-payment or co-insurance amount you are responsible %**_____ **$** _____
5. **What is the maximum to your out-of-pocket limit? Individual $** _____ **Family $** _____

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) **The applicant resides in either Anoka, Carver, Dakota, Hennepin, Ramsey, Scott or Washington county.**
3) **An evaluation has been completed at the applicant's expense and a determination has been made that the applicant will benefit from speech therapy.**
4) **RiteCare® is a secondary provider after all insurance and government assistance.**
5) **The following therapy services are not covered by this grant:**
   a. **English as a Second Language**
   b. **Stuttering**
   c. **Deaf/Hard-of-hearing**

6) **The grant is for two years (commencing from the date of approval) and will not exceed $7,500. If the applicant's treatment plan is completed before the end of the grant period, we ask that RiteCare® be advised so any unused funds can be released for another child.**

7) **Payment will be made directly to your provider, upon receipt by RiteCare® of the following items: official bill from provider and list of services provided.**

8) **RiteCare® will pay your service provider at the lesser of their contractual rate with the insurance company (if any) or $100 (periodically reviewed and adjusted) if there is no contractual rate or the insurance policy does not cover the applicant's diagnosis. The service provider may bill you for the difference if there is no insurance for the applicant's diagnosis.**

9) **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 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, Inc. does not review either the credentials, expertise or abilities of any therapist.***

ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL

Remarks/comments:

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

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

Official Use Only

ACTION OF BOARD OF DIRECTORS

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

Rev. 11/15/18