



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

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

RiteCare® Speech Therapy Grant Application

(Official Use Only) Date Received _____

SECTION I

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

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

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

Younger siblings birthdates

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SECTION II

Has your child been evaluated for speech/language concerns?

YES / NO

If yes, give speech therapist name, location and date where evaluation took place:

(Please note RiteCare® grants do not cover cost of evaluation)

Was speech therapy recommended?

YES / NO

If so, what speech therapy was recommended and why?

Has previous speech therapy treatment been received?
 If yes, give name of provider(s) and approximate dates of speech therapy

YES / NO

Speech Therapy Treatment Provider Information - Private		
Business Name		Contact Person
Address		
City	State / Zip Code	Telephone Number
Dates of speech therapy treatment (MM/YYYY to MM/YYYY)		Is child currently in speech therapy treatment? YES/NO

Speech Therapy Treatment Provider Information - School		
School Name		Contact Person
Address		
City	State / Zip Code	Telephone Number
Dates of speech therapy treatment		

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

SECTION III

Does child have coverage for speech therapy under any medical insurance plan or State/Federal assistance? YES / NO (circle one) Complete the rest of this section even if you responded "no".

Health insurance plan information for applicant:

Name of company_____

Policy number_____

Dates of policy period ___/___/___ to ___/___/___

Does policy provide benefits for child's diagnosis? Yes/No (circle one) Complete the rest of this section even if you responded "no". The application is **not complete without this information**.

1. Annual limit for number of therapy sessions (likely includes speech, physical and occupational therapy as one amount)? _____ soft or hard limit (circle one). Call the insurance company if you do not know.
2. Provide policy deductible amount: Individual \$ _____
3. Provide co-payment or co-insurance amount you are responsible for % _____ or \$ _____
4. What is your out-of-pocket maximum? Individual (if none stated, provide family maximum) \$ _____

Attach a copy of both sides of health insurance card (electronically if possible).

SECTION IV

CONDITIONS OF APPLICATION PARENTS OR LEGAL GUARDIAN - READ CAREFULLY

Application is hereby made for a speech therapy 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.

We hereby agree as follows:

- 1) We have read the Frequently Asked Questions on the RiteCare website.
- 2) The applicant is between the ages of two to seven (2 - 7) years.
- 3) Applicant is a resident of Anoka, Carver, Chisago, Dakota, Goodhue, Hennepin, Isanti, LeSueur, McLeod, Ramsey, Rice, Scott, Sibley, Sherburne, Washington or Wright County.
- 4) A formal Speech and Language Evaluation (not a school individualized student evaluation - IEP) conducted by a state licensed Speech and Language Pathologist must be included with the application. The evaluation must include a description of the standardized assessment tool(s) used or attempted, along with standardized scores and a summary of the results of the evaluation including recommendations for frequency and duration of therapy. The evaluation must include the applicant's diagnosis of a communication disorder. Evaluations must be on professional letterhead and dated within one year of the date of the application. All evaluations are completed at the applicant's expense.

Attach a copy of evaluation to this application.

- 5) Family adjusted gross income must meet the income guidelines found under grant eligibility of the RiteCare MSP web site.

Attach a copy of the first two pages of your most recently filed Form 1040.

- 6) RiteCare® is a secondary provider after all insurance and government assistance.
- 7) The following speech therapy services are not covered by this grant, a) English as a Second Language, b) stuttering, c) treatment of swallowing dysfunction and/or oral function for feeding, and d) deaf/hard-of-hearing. No occupational therapy services are covered by this grant.
- 8) The grant is for two years (commencing with the grant effective date) and will not exceed \$7,500. Only one grant can be awarded to a child. 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.

9) Payment will be made directly to your speech therapy provider, upon receipt by RiteCare® of the following items: official bill from the speech therapy provider with list of speech therapy services provided.

10) RiteCare® will pay your speech therapy provider the lesser of their contractual rate with the insurance company (if any) or net amount after insurance benefits are applied. If there is no contractual rate or the insurance policy does not cover the applicant's diagnosis when the speech therapy provider accepts assignment of benefits, RiteCare® will pay your speech provider up to \$110 (periodically reviewed and adjusted) (50% of that rate when they do not accept assignment of benefits). The speech therapy provider may bill you for the difference between what they bill and any reimbursements they receive.

11) We acknowledge that the selection of the speech therapy provider was our selection and the speech therapy provider has not been recommended by RiteCare of Minneapolis-St. Paul, Inc. In addition, we acknowledge that the selection of the speech therapy provider is at our own risk. In addition, we hereby release and discharge RiteCare of Minneapolis-St. Paul, Inc. from all liability and claims arising out of or related to the selection of any speech therapy provider or the provision of services by that speech therapy provider. This release is freely and voluntarily given. RiteCare of Minneapolis-St. Paul, Inc. does not review either the credentials, expertise or abilities of any speech therapist.

12) We will cooperate to provide supplemental and/or updated information for this application or for a grant should one be awarded to our son or daughter.

13) We authorize disclosure of information between RiteCare of Minneapolis-St. Paul, Inc. a) the speech therapy provider we select, b) any billing agent the speech therapy provider may use and, c) our health insurance company.

ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL

Remarks/comments can be provided on a supplemental page.

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

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

**Please mail application and required attachments to:
RiteCare of Minneapolis-St. Paul, Inc
2011 Dupont Avenue South
Minneapolis, MN 55405
Or scan (please no phone pictures of application) and email to:
grants@ritecaremsp.org**