

AID-L GIVING TREE SCHOLARSHIP



DATE SUBMITTED:

SUBMITTED TO:

ADVANCED INSTITUTE FOR DEVELOPMENT AND LEARNING
10 JIMMY DOOLITTLE DRIVE SUITE B GREENVILLE, SC 29607

SUBMITTED FOR (Child):

SUBMITTED BY:

CONTACT EMAIL AND PHONE #:

PLEASE INITIAL IF YOU ARE WILLING TO BE ADDED TO OUR VOLUNTEER DATABASE
(this information will not be a deciding factor in our scholarship app.)

I. ELIGIBILITY REQUIREMENTS (Please check)

- CHILD IS UNDER 21 YEARS OF AGE
- FAMILY MUST NOT EXCEED MAXIMUM ELIGIBILITY FAMILY INCOME BASED ON GROSS FAMILY INCOME WITH A MAXIMUM OF \$145,000 FOR A FAMILY OF 5
- CHILD IS UNDER THE CARE OF A LICENSED MEDICAL PROFESSIONAL AND FAMILY IS APPLYING FOR TREATMENT/EVALUATION/SERVICES PRESCRIBED BY A MEDICAL DOCTOR (M.D.), DOCTOR OF OSTEOPATHIC (D.O.), OR DOCTOR OF AUDIOLOGY (Au.D.).
- CHILD MUST RECEIVE ANY GRANTED SPEECH-LANGUAGE AND/OR FEEDING SERVICES THROUGH THE ADVANCED INSTITUTE FOR DEVELOPMENT AND LEARNING.

II. ATTACH REQUIRED DOCUMENTS

IF WORKING PLEASE INCLUDE:

- COPY OF MOST RECENT SUBMITTED IRS 1040 TAX FORM. IF CHILD IS NOT ON MOST RECENT IRS 1040, ADDITIONAL DOCUMENTATION MAY BE REQUIRED (E.G. RECENT BIRTH, ADOPTION).
- TWO CONSECUTIVE PAYCHECK STUBS FOR EACH WORKING INDIVIDUAL IN THE HOUSEHOLD
- COPY OF INSURANCE CARDS
- COMPLETED AND SIGNED PHYSICIAN REFERRAL AND CERTIFICATE OF MEDICAL CONDITION

IF NOT WORKING:

- MOST RECENT 30 DAYS OF INCOME (INCLUDING SSI STATEMENTS, DISABILITY STATEMENTS, CHILD SUPPORT, FOOD STAMPS, ALIMONY ETC.)

III.

GRANT REQUEST

*Up to \$1,250.00. Please include **amount** (e.g. \$800) and **short reason for your request.** (e.g. aged out of BabyNet, out of network provider, awaiting Medicaid approval).

Amount:

Reason:

IV.

BUDGET

COMMENTS (What do you need the money for?)

ITEM DESCRIPTION	PRICE	QUANTITY	TOTAL
TOTAL			

*DO NOT FORGET TO ATTACH REQUIRED DOCUMENTS. YOU CAN EXPECT TO HEAR BACK WITHIN 2-4 WEEKS OF SUBMISSION. PLEASE KEEP THIS IN MIND AND APPLY EARLY. THANK YOU!

PHYSICIAN'S CERTIFICATION OF MEDICAL CONDITION – (AID-L GRANT REQUEST)

CHILD'S INFORMATION (TO BE COMPLETED BY PARENT/GUARDIAN)

Child's Name: _____ Child's DOB: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

CHILD'S MEDICAL INFORMATION (TO BE COMPLETED BY THE CHILD'S PHYSICIAN)

Note: Physician must be an M.D., D.O., or, for hearing related conditions, an Au.D. The parent/legal guardian listed above has applied for a service/equipment grant with the Advanced Institute for Development and Learning (AID-L). Please complete the following medical information.

Child's Primary Diagnosis: _____

Child's Secondary Diagnosis (if applicable): _____

How are the current diagnoses impacting the child's life? (check all that apply):

- Medically
- Socially
- Psychologically/Behaviorally
- Other: _____

I recommend the following (indicate and describe all that apply) and describe why they are needed:

- Treatment: _____

- Equipment: _____

- Other: _____

Additional Notes/Concerns: _____

PHYSICIAN INFORMATION – ITEMS MARKED * ARE REQUIRED TO PROCESS FORM

*Physician Name: _____ *Title: _____

Provider ID #: _____ Telephone: _____

Address: _____

*Signature: _____ Date: _____

Thank you for taking the time to complete this information. Please return this form back to the child's parent/legal guardian so that they may attach it to their child's grant application.

FOR OFFICE USE ONLY

**DOCUMENTS RECEIVED
(DATE)**

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REVEIWED BY:

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LETTER FROM THERAPIST (IF APPLICANT IS A CURRENT AID-L PATIENT)

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GRANT DETERMINATION:

APPROVED:

NOT APPROVED:

AMOUNT: _____

Approved by: _____

Date: _____

Title: _____

Authorized by Treasurer: _____

Date: _____