

# Nancy Streit Foundation Grant Application

## Applicant Information

Parent/Guardian Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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## Therapy Information

Type of Therapy Requested (check all that apply):

- Speech Therapy
- Occupational Therapy
- ABA Therapy
- Physical Therapy
- Other: \_\_\_\_\_

Name of Therapy Provider: \_\_\_\_\_

Provider Phone/Email: \_\_\_\_\_

Has your child been evaluated by a licensed professional in the past year?

- Yes
- No

If yes, please attach evaluation and treatment recommendations.

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## Financial Need

### Annual Household Income Range:

- Under \$25,000
- \$25,000–\$50,000
- \$50,001–\$75,000
- \$75,001–\$100,000
- Over \$100,000

### Do you currently have health insurance?

- Yes
- No

### Does insurance cover the requested therapy?

- Fully
- Partially
- Not Covered

Please briefly explain any financial hardship that prevents your child from receiving therapy:

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## Funding Request

Amount Requested: \$ \_\_\_\_\_

Number of Therapy Sessions Requested: \_\_\_\_\_

Estimated Cost Per Session: \$ \_\_\_\_\_

How will this grant help your child?

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## Certification

I certify that the information provided is true and complete to the best of my knowledge. I understand that the Nancy Streit Foundation may request additional documentation to verify eligibility.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## Required Documents Checklist

- Completed Application
  - Therapy Evaluation or Prescription
  - Most Recent Tax Return or Proof of Income
  - Insurance Explanation of Benefits (if applicable)
  - Therapy Cost Estimate or Invoice
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## Foundation Use Only

Application Received: \_\_\_\_\_

Approved:  Yes  No

Grant Amount Awarded: \$ \_\_\_\_\_

Reviewer Notes:

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