Family Hope Foundation

Scholarship Application

Family Hope Foundation
7086 8th Avenue
Jenison, MI 49428
(616) 729-8833
www.familyhopefoundation.org

IMPORTANT: New addition to application

Thank you for applying for a Family Hope Foundation Scholarship. In order for you to qualify, we must receive the following documentation alongside your application **no later than August 2, 2026.**

- ☑ ****Evidence of disability** – This could be a letter from the recipient's doctor or transcript from a doctor visit listing the recipient's diagnosis. **The diagnosis *must* come from a licensed doctor, physician, or clinical psychologist / psychiatrist. We will *not* accept an IEP, a letter or statement from a therapist (unless the therapist is the licensed diagnosing psychologist or psychiatrist), or a letter from school.**

- ☑ ***Insurance coverage for therapy requested** – We need a copy of the section of your insurance plan that discusses therapy coverage (please include deductible information if applicable) OR a letter from your insurance company denying coverage. (Denial letters must be dated within the last year and must be for the same therapy and from the same provider the scholarship was approved for.)
  **This is not necessary if the applicant has Medicaid.*

- ☑ **Copy of the recipient's insurance card(s)** – If Medicaid card does not say "Medicaid," "MIChild" or "MIHealth," you must submit proof that it is Medicaid (copy of your letter from the State).

Mailed with your application

OR

These documents may be emailed directly to
madeline.puckett@thefamilyhopefoundation.org

Applicant Name: _____

Please read the Scholarship Guidelines thoroughly before completing this application.

- Every question must be answered for the application to be complete.
- Applications **ONLY** accepted January 1 - February 1 at midnight **OR** July 1 - August 1 at midnight.
- Applicants **must** have a formal diagnosis from a physician, psychologist, or psychiatrist **before** applying.

About the Applicant:

1. Applicant's Name (First, Last) _____ _____

Any previous names (if applicable):_____

2. Does the applicant have an official diagnosis from a physician, psychiatrist, or psychologist? [ ]Yes [ ]No

*__NOTE: The applicant MUST have a diagnosis from a physician, psychologist or psychiatrist BEFORE applying. This is required for submission, along with a discussion of your insurance coverage and copy of your insurance card, alongside your application.__

3. Applicant Diagnoses (Please list the formal primary and secondary diagnoses or disabilities):

_____

_____

4. Please indicate ALL categories of diagnoses that the applicant has received:

[ ]Autism Spectrum Disorder [ ]Cognitive Impairment [ ]Deaf or Hard of Hearing [ ]Emotional Impairment (e.g., depression, anxiety, etc.) [ ]Learning Disability [ ]Physical Impairment [ ]Severely Multiply Impaired [ ]Speech and Language Impairment [ ]Traumatic Brain Injury [ ]Visual Impairment [ ]Other Health Impairment (e.g., ADHD, epilepsy, etc.)

5. Birthdate: _____/_____/_____ **6.** Gender:_____

7. Race/Ethnicity- Please indicate all that apply:

[ ]American Indian or Alaska Native [ ]Asian [ ]Black or African American [ ]Hispanic or Latino

[ ]Middle Eastern or North African [ ]Native Hawaiian or Other Pacific Islander [ ]White

8. Briefly tell us about who the applicant is as a person (attach an additional page, if needed):

_____

_____

_____

_____

Therapy Information:

9. List **all** therapies that the applicant currently receives at **school (S)** or receives **privately (P)** and check the appropriate choice.

_____ [ ]S [ ]P _____ [ ]S [ ]P

_____ [ ]S [ ]P _____ [ ]S [ ]P

10. Which of the categories listed best describes the type of therapy you are requesting? If none apply, please indicate "Other" and write in the category.
[ ] ABA Therapy [ ]Auditory (hearing) Therapy [ ]Counseling [ ]Craniosacral Therapy
[ ]Hippotherapy/Equine Assisted Services [ ]Massage Therapy [ ]Occupational Therapy [ ]Physical Therapy
[ ]Reading Therapy [ ]Speech and Language Therapy [ ]Vision Therapy
[ ]Other:_____

11. Please explain why the therapy you are requesting a scholarship for will be beneficial to the applicant. (Attach an additional page, if needed):

_____

_____

_____

_____

12a. What would you expect to pay out-of-pocket for the applicant to receive this therapy over the next 6 months? $_____ (See the Guidelines for more information on this question.)

12b. Therapy Cost Comments (This question is optional. You can use it to share any additional information about how this therapy is billed that would help us understand how you calculated the out-of-pocket cost in the question above.)

_____

_____

13. Amount of scholarship being requested: $ _____ (not to exceed $1,000)

14. Check the applicant's medical coverage (check all that apply):

[ ]Private Insurance [ ]Medicaid/MI Child [ ]Children's Special Health Care [ ]None

15. Will insurance cover any portion of the costs associated with this therapy? (Check your latest policy before answering) [ ]Yes [ ]No [ ]Applicant does not have any insurance coverage, as noted above.

16. Therapy Provider **(business name, not therapist**): _____
Note, this provider must be an already approved therapy provider listed on our website.

Therapy Provider Address:

_____
Street City State Zip

Therapy Provider Phone: (_____)_____

17. Has the applicant been evaluated by this provider?: [ ]Yes [ ]No

18. Has the applicant received therapy from this provider?: [ ]Yes, currently [ ]Yes, in the past [ ]No

Household Information:

19. Who is responsible for the applicant? [ ]Parent(s) [ ]Guardian(s) [ ]Self

20. Parent / Guardian #1 or Self

First Name, Last Name _____ _____

Date of Birth: _____ Does this person receive therapy? [ ]Yes [ ]No

Cell Phone: (_____)_____ May we text this number? [ ]Yes [ ]No

Primary Address:

_____

Street City State Zip

County (**NOT** Country): _____

(Counties served: Kent, Ottawa, Muskegon, Allegan, Barry, Kalamazoo, Ionia, Newaygo, Montcalm, Van Buren, and Calhoun)

Primary Email: _____

Employer name, if applicable: _____

Parent / Guardian #2 (if applicable)

First Name, Last Name _____ _____

Date of Birth: _____ Does this person receive therapy? [ ]Yes [ ]No

Cell Phone: (_____)_____ May we text this number? [ ]Yes [ ]No

Address, if different:

_____

Street City State Zip

Employer name, if applicable: _____

21. **Dependents-** Please list ALL dependents names and dates of birth living in the household below.

First _____ Last _____ DOB:_____ Require therapy? [ ]Y [ ]N
First _____ Last _____ DOB:_____ Require therapy? [ ]Y [ ]N
First _____ Last _____ DOB:_____ Require therapy? [ ]Y [ ]N
First _____ Last _____ DOB:_____ Require therapy? [ ]Y [ ]N
First _____ Last _____ DOB:_____ Require therapy? [ ]Y [ ]N

22. Does the applicant reside in a group home? (If yes, please skip to question 23): _____

22b. Number of dependents residing in the home (including the applicant): _____

22c. Number of adult caregivers residing in the home: _____

22d. How many additional dependents residing in the home have disabilities that require therapy? _____

22e. Will another family member also be applying for a scholarship at this time? ( ) Yes ( ) No

23. What is your total/combined Household Annual Income?

[ ]$0 - $24,999 [ ]$25,000 - $49,999 [ ]$50,000 - $74,999 [ ]$75,000 - $99,999
[ ]$100,000 - 124,999 [ ]$125,000 - $149,999 [ ]$150,000 and above

24. How will receiving a therapy scholarship be financially beneficial to your family? (Attach an additional page, if needed):

_____

_____

_____

_____

_____

_____

Please continue to next page

Designated Scholarship Program

Our Designated Scholarship Program is a program that allows companies and organizations to sponsor a scholarship recipient. Partnering with other groups allows Family Hope Foundation to raise additional funds and provide assistance to more families. **Receiving a scholarship through our Designated Scholarship Program *requires* the applicant family to:**

- Sign a release that gives us permission to share the applicant's first name, age, disability, story and therapy needs with the sponsoring group to create an individual connection. No personal contact information will be disclosed.
- Be willing to adhere to the request of the sponsoring group for a personal connection. These requirements vary by sponsoring group, but could be things such as:
    - Send a personal thank you note with a photo to the sponsoring group.
    - Attend a meeting of the group to introduce your child and say thank you.
    - Write a letter after the applicant's therapy is complete, explaining its value and your gratitude.

25. Are you willing to accept funds from our Designated Scholarship Program (see guidelines)? ( )Yes ( )No

26. How did you hear about Family Hope Foundation? _____

Application was completed by: _____

Relationship to the applicant: _____

[ ]I have read and agree to follow all Scholarship Guidelines (found on Family Hope Foundation website)

Application Verification: If the applicant is selected to receive a scholarship, I commit to complying with all follow up requirements and paperwork submissions. I understand that failure to submit paperwork within the one-month deadline could result in forfeiture of the scholarship.

Signed Name and Date:

_____