# Shiny Brains Foundation – Family Support Application Form

Purpose: The Shiny Brains Foundation is dedicated to helping families of children with neurodevelopmental differences access continued therapies, educational support, and essential resources. Please complete this form so we can understand your family's needs and determine how we can best assist you.

## ■ Parent / Guardian Information

Full Name: _____

Email Address: _____

Phone Number: _____

Home Address: _____

City / State / ZIP: _____

Preferred Language: ■ English ■ Spanish ■ Other _____

Best way to contact you: ■ Phone ■ Email ■ Text

## ■ Child Information

Child's Full Name: _____

Child's Age: _____

Diagnosis or Area of Concern: _____

Current Therapies Receiving: ■ Speech ■ OT ■ PT ■ ABA ■ Behavioral ■ Other: _____

## ■ Insurance and Medicaid Information

Insurance Provider Name: _____
Policy / Member ID Number: _____
Medicaid or CHIP Number (if applicable): _____
Case Manager or Social Worker Name: _____
Case Manager Contact Information: _____
Are therapy services currently billed to Medicaid? ■ Yes ■ No
If denied or pending, please describe reason: _____

## ■ Type of Support Needed (Select all that apply)

■ Financial Assistance for Therapies
■ Transportation to Therapy Appointments
■ Food Assistance
■ Educational Materials / Technology Support
■ Parent Education & Training
■ Other: _____

## ■ Financial Information

Total Monthly Household Income:
■ Under $2,000 ■ $2,000–$4,000 ■ $4,001–$6,000 ■ Over $6,000

Number of People Living in Household: _____

Are you currently receiving assistance from any other programs? ■ Yes ■ No
If yes, please list: _____

Do you have active health insurance coverage for your child's therapy services? ■ Yes ■ No
If yes, which provider: _____

Are there current delays in therapy coverage or insurance approval? ■ Yes ■ No
Please explain: _____

**■ Financial Hardship / Verification of Need**

Please explain your current financial hardship or reason for requesting assistance. Include any recent changes in income, employment, or medical expenses that affect your ability to pay for therapy.

_____
_____
_____

**❤■ Impact Statement**

Please tell us how receiving support from the Shiny Brains Foundation would help your child and family:

_____
_____
_____

**■ Supporting Documents (optional)**

■ Therapy invoices or estimates
■ Doctor's referral or diagnosis report
■ Proof of income or hardship statement

**■ Authorization and Release of Information**

I authorize the Shiny Brains Foundation to verify any information provided in this application, including contacting therapists, healthcare providers, or insurance representatives to confirm service needs, benefits, or eligibility. I understand that information will be kept confidential and used solely to determine eligibility for assistance.

I consent to the release of limited health information necessary for the Shiny Brains Foundation to evaluate this request for support. I understand my personal and medical information will not be shared outside of the review process.

**■■ Program Integrity & Fraud Prevention**

I certify that all information provided is true and complete. I understand that providing false or misleading information may result in denial or termination of assistance and possible legal action.

**■ Optional Demographics (for reporting only)**

Race/Ethnicity (optional): ■ African American ■ Hispanic/Latino ■ White ■ Asian ■ Other _____
Primary Language at Home: _____
County of Residence: _____

**■ Referral Source**

How did you hear about the Shiny Brains Foundation?
■ Therapist / Clinic ■ Hospital / Case Manager ■ School ■ Social Media / Website ■ Other: _____

**■ Acknowledgment**

I understand that completing this application does not guarantee financial support. All information provided is true to the best of my knowledge.

Signature: _____ Date: _____

Thank you for applying. Our team will review your request and contact you within 7–10 business days.