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**		**Middle**
Home Address		**City**	**State / Zip Code**
County	**Home Phone Number**	**Sex**	**Birth date (MM/DD/YY)**

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

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

Younger siblings birthdates

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? **YES / NO**
If yes, give name of provider(s) and approximate dates of speech therapy

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 annual therapy visits? _____ soft or hard limit (circle one)**
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 $ _____**

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.

I 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) **RiteCare® is a secondary provider after all insurance and government assistance.**
6) **The following speech therapy services are not covered by this grant, a) English as a Second Language, b) Stuttering, and c) Deaf/Hard-of-hearing. No occupational therapy services are covered by this grant.**

7) **The grant is for two years (commencing's 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.**

8) **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 and list of speech therapy services provided.**

9) **RiteCare® will pay your speech therapy provider at their contractual rate with the insurance company (if any) or $103 (periodically reviewed and adjusted). 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 (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.**

10) **The undersigned acknowledges that he/she is selecting the speech therapy provider of his/her choice and the speech therapy provider has not been recommended by RiteCare of Minneapolis-St. Paul, Inc. The undersigned acknowledges that he/she is selecting the speech therapy provider at his/her own risk. In addition, the undersigned hereby releases and discharges RiteCare of Minneapolis-St. Paul 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.***

11) **The undersigned authorize disclosure of information between RiteCare of Minneapolis-St. Paul, Inc. a) the speech therapy provider you select and, 2) any billing agent the speech therapy provider may use.**

ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL

Remarks/comments can be provided on supplemental pages.

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