Florida Elks
CHILDREN'S THERAPY SERVICES
Mobile In-Home Therapy since 1999

Colleen C. Gallant, Director

Dear Prospective Patient:

Florida Elks Children's Therapy Services is a program that offers ***free*** in home therapy services to Florida children. These services are provided by a licensed Physical Therapist or licensed Occupational Therapist employed by the Florida Elks. These rehabilitative services are necessary to be rendered in the home because of the absence of these services locally, or because of the patient being medically infirmed at home.

Eligibility for treatment will be based on a number of factors including medical and other criteria; such as but not limited to:

- The patient must be a resident of Florida.
- The patient must be between the ages of birth and 18 years.
- The patient must have a condition necessitating Physical or Occupational therapies.
- The Patient must have rehabilitative potential
- The patient must have financial need for free services.

All questions on the application must be completed. Failure to do so will result in a delay in processing your application. If you have any questions, please don't hesitate to call on our toll-free number, 1-800-523-1673

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Post Office Box 49, Umatilla, Florida 32784-0049
352-801-6445 or 800-523-1673

Revised 02/2017

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OFFICE USE ONLY	
Received Date:	Approved Date:
Referred to (Therapist):	

Application for Services

P.O. Box 49, Umatilla, FL 32784-0049 | 800-523-1673 | www.elkstherapy.com | cgallant@floridaelkscts.org

Child's Information

Name: _____ (First) _____ (Middle) _____ (Last)

D.O.B: _____ (MM/DD/YYYY) Age: _____ ☐ Years ☐ Months Sex: ☐ MALE ☐ FEMALE

Address: _____ City: _____ Zip Code: _____

FECTS Services Applying for: ☐ Physical ☐ Occupational

Has the Child received FECTS services before? ☐ Yes ☐ No If yes, when? _____

Who referred you to FECTS? _____

Name of Child's School: _____ Grade: _____

Medical Information

Child's Diagnosis/Therapeutic Concerns:

_____

_____

Is the Child currently receiving any other therapies? ☐ Yes ☐ No

If yes, what kind? _____

_____

Child's Physician: _____

Address: _____ City: _____

Zip Code: _____ Phone: _____ Fax: _____

Child's Health Insurance? ☐None ☐Private ☐Medicaid ☐Other: _____

Parent/Legal Guardian Information

Parent/Legal Guardian #1

Name: _____ (First) _____ (Last) D.O.B. _____ (MM/DD/YYYY)

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

Does Child live with? ☐ Yes ☐ No

Relationship to Child: ☐Parent ☐Grandparent* ☐Foster/Adoptive* ☐Other*: _____

*Please provide any necessary documents to show Guardianship

Employer Name: _____ Phone: _____

Parent/Legal Guardian #2

Name: _____ (First) _____ (Last) D.O.B. _____ (MM/DD/YYYY)

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

Does Child live with? ☐ Yes ☐ No

Relationship to Child: ☐Parent ☐Grandparent* ☐Foster/Adoptive* ☐Other*: _____

*Please provide any necessary documents to show Guardianship

Employer Name: _____ Phone: _____

Parent/Legal Guardian #3 (if applicable)

Name: _____ (First) _____ (Last) D.O.B. _____ (MM/DD/YYYY)

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

Does Child live with? ☐ Yes ☐ No

Relationship to Child: ☐Parent ☐Grandparent* ☐Foster/Adoptive* ☐Other*: _____

*Please provide any necessary documents to show Guardianship

Employer Name: _____ Phone: _____

Financial Information

What is your household's total combined yearly income? ☐$0 - $10,000 ☐$10,000 - $20,000 ☐$20,000 - $30,000 ☐$30,000 - $40,000 ☐$40,000 - $50,000 ☐$50,000 - $75,000 ☐$75,000 & over

Tell Us Your Story

How can FECTS help?

Acknowledgement

I certify that the provided information on this application is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification by the Florida Elks Children's Therapy Services.

Parent/Legal Guardian Signature: _____ **Date:** _____

THERAPIST USE ONLY

Date: _____ Therapist Name: _____

Notes:

Therapist Signature: _____ **Date:** _____

Approved ☐ **Denied** ☐

Director Signature: _____ **Date:** _____