# VARIETY EQUIPMENT / THERAPY APPLICATION

11840 Westline Industrial Dr, Suite 220 | St. Louis, MO 63146
Phone: 314-720-7708 | Fax: 314-375-9557

## CHECKLIST FOR VARIETY APPLICATION:

| For households that DO file taxes: | For households that DO NOT file taxes: |
|---|---|
| ✓ Completed application (pages 2-3) | ✓ Completed application (pages 2-3) |
| ✓ Current photo of child (optional) | ✓ Current photo of child (optional) |
| ✓ Copy of first page of the:<br><br>**TWO MOST RECENT YEARS** federal income tax return (Form 1040) from the person(s) claiming the child as a dependent. The first page should include Adjusted Gross Income and a list of dependents.<br><br>Example: Page 1 of years 2020 and 2021 tax returns showing your adjusted gross income and list of dependents. | ✓ Copy of award letter<br><br>If you do not have a copy of your award letter you can request one by visiting:<br><br>www.socialsecurity.gov/myaccount or call toll free 1-800-772-1213 (TTY 1-800-325-0778) |
| ✓ If your **adjusted gross income is above $85,000** you must also **complete the monthly expenses chart** on page 4 of this application | |

**NOTICE**: An incomplete application will delay the review process until all information (detailed above) has been received.

# EQUIPMENT / THERAPY APPLICATION

**Child's Information**

Child's Name: _____

Birth Date: _____ Male/Female: _____

Social Security Number: _____

Child's Primary Diagnosis:

_____

_____

Additional Diagnoses:

_____

_____

**Parent/Guardian's Information**

Primary Guardian(s): _____

_____

Relationship to child: _____

Primary Address: _____

_____

City/State: _____ ZIP: _____

County: _____

Telephone: _____

Email: _____

***Your response to the following questions is optional and will not affect the status of your application. The information requested is useful to Variety's pursuit of additional funding to support our assistance programs.***

***Child's race/ethnicity (optional)***

| | | |
|---|---|---|
| (___) White | (___) Black or African American | (___) Asian |
| (___) Hispanic or Latino or Spanish origin | (___) Middle Eastern or North African | (___) Native Hawaiian or Pacific Islander |
| (___) American Indian or Alaskan Native | (___) Some Other Race | (___) Multi-Racial |

***Developmental Disability Documentation, if applicable (optional)***

Missouri Department of Mental Health, Division of Developmental Disabilities ID #: _____

OR if your child is currently enrolled in Missouri First Steps, please attach a copy of your child's First Steps IFSP, page 1.

**Request**

Nature of Request (e.g. orthopedic equipment, wheelchair, therapy)

_____

_____

_____

Are you currently working with an equipment company or therapist? Yes ☐ No ☐

If yes, what is the name of the equipment company or therapy provider? _____

**Household Income Information**

Number of earners in the household: _____ Number of members in the household: _____

Earner #1's income per Year: $_____
Occupation and Current Employer: _____
Company Address: _____
How long have you been employed by this employer? _____

Earner #2's income per Year: $_____
Occupation and Current Employer: _____
Company Address: _____
How long have you been employed by this employer? _____

Describe any extraordinary expenses or special circumstances. Be specific as to the expense and anticipated duration of the circumstances.

_____

_____

_____

_____

**Medical Personnel:** (Primary Care Physician and/or Therapist)

| | |
|---|---|
| Name: | Name: |
| Address: | Address: |
| City/State/Zip: | City/State/Zip: |
| Phone: | Phone: |

**School Child Attends:** _____ **School District Child Attends**: _____

**Additional Children Residing in the Household**:

| Name | Age | Name | Age |
|---|---|---|---|
| 1. | | 3. | |
| 2. | | 4. | |

**How did you hear about Variety?** _____

**Assessments**

The funding of equipment/therapy would not be possible without many individuals, companies, and foundations within the Greater St. Louis community who contribute to Variety. Our programs depend on these benefactors.

With that in mind, **you will be required** to complete a survey to report how your child's piece of equipment/therapy has impacted his/her life, and that of your family.

Your responses will be critical to increasing funding for Variety programs; all responses will be kept confidential.

☐ **I acknowledge that I will be required to complete a survey if I am provided equipment / therapy.**

Parent or Guardian Signature: _____

Printed Name: _____

**Completed applications & financial documentation can be submitted by:**

Mail: 11840 Westline Industrial Dr, Suite 220, St. Louis, MO 63146
Fax: 314-375-9557
Email: Julie@varietystl.org

***An incomplete application will delay the review process until all information has been received.***
***(see checklist on page 1 of this application)***

## Fill this out ONLY if your adjusted gross income is OVER $85,000

**MONTHLY TAKE HOME INCOME**

| | |
|---|---|
| Earner #1's take home income per month | $ |
| Earner #2's take home income per month | $ |
| Social security | $ |
| Child support/maintenance | $ |
| **Total monthly income (add the income lines above)** | **$** |

**MONTHLY EXPENSES**

| | | |
|---|---|---|
| Home expenses | Mortgage/rent | $ |
| | Phone | $ |
| | Cable | $ |
| | Other | $ |
| Food expenses | Groceries | $ |
| | Special dietary food/supplements | $ |
| Child related expenses | Daycare/babysitting | $ |
| | Other | $ |
| Debt obligations | Student loans | $ |
| | Credit card loans | $ |
| | Bank loans | $ |
| | Medical bills | $ |
| | Child support paid/alimony paid | $ |
| Transportation expenses | Car loans/public transportation costs | $ |
| | Car insurance | $ |
| | Gasoline | $ |
| | Maintenance/repair | $ |
| Health care expenses | Health insurance (plan and HSA) | $ |
| | Therapy/doctor visits | $ |
| | Medicine | $ |
| | Medical supplies | $ |
| | Other | $ |
| Other expenses | Donations/charitable giving | $ |
| | Savings/IRA | $ |
| | Extracurricular activities | $ |
| | Vacation | $ |
| | Entertainment | $ |
| | Personal (haircuts/toiletries/ gifts/etc.) | $ |
| | Petcare expenses | $ |
| | Other | $ |
| **Total monthly expenses (add the expense lines above)** | | **$** |

| | |
|---|---|
| **Total monthly income (from above)** | $ |
| **Subtract-** | |
| **Total monthly expenses (from above)** | $ |
| **Monthly Surplus (total monthly income - total monthly expenses)** | $ |