VARIETY EQUIPMENT / THERAPY APPLICATION

11840 Westline Industrial Dr, Suite 220 | St. Louis, MO 63146
Phone: 314-720-7700 | 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)
✓ Copy of first page of the: **MOST RECENT YEAR'S** 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.	✓ Copy of SSI award letter If you do not have a copy of your award letter you can request one by visiting: www.socialsecurity.gov/myaccount or call toll free 1-800-772-1213 (TTY 1-800-325-0778)
After the application is received, you may be asked to provide proof of diagnosis and/or home address	After the application is received, you may be asked to provide proof of diagnosis and/or home address

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: _____

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

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

Does the child have a DMH Waiver? (circle answer) Yes No

If yes, circle the waiver type below:

Partnership for Hope MOCDD (Sarah Lopez) Community Support Comprehensive

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

Insurance Information

Is the child enrolled in Medicaid? Yes No

Does the child have insurance coverage other than Medicaid? Yes No

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: $_____
Current Employer: _____
Job Title: _____

Earner #2's income per Year: $_____
Current Employer: _____
Job Title: _____

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**: _____

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: Equipment@varietystl.org or Therapy@varietystl.org

An incomplete application will delay the review process until all information has been received.

MONTHLY TAKE HOME INCOME	
Earner #1's take home per month	
Earner #2's take home per month	
Social Security Income	
Child Support/Maintenance	
Total Monthly Income	
Home Expenses	
Mortgage/Rent	
Utilities/Phone/Internet/Cable	
Home Repairs	
Insurance (if not included in mortgage)	
Transportation	
Gas	
Auto Maintenance/Repair	
Auto Insurance	
Debt	
Auto Loan - monthly payment	
Student Loan - monthly payment	
Bank/Credit Card Loan - monthly payment	
Living Expenses	
Food (Groceries/Restaurants)	
Personal/Clothing/Petcare	
Child Care	
Gifts	
Extracurricular Activities	
Medical Expenses (Outside of FSA/H.S.A.)	
Prescriptions	
Therapy	
Doctor Visits/Copays/Medical Supplies	
Health Insurance (if not deducted pre-tax)	
Other Expenses	
Donations/Charity	
Vacation/Entertainment	
Child Support/Alimony	
Savings/IRA	
Other:	
Other:	
TOTAL MONTHLY EXPENSES	
Monthly Surplus (Income - Expenses)	

Expenses Taken Out of Paycheck	
Pre-Tax Expenses	
Health Insurance	
F.S.A./H.S.A.	
Retirement	
Other:	
Total	

Please explain any extra expenses or extenuating circumstances that you would like for the Review Team to consider.

Thank you for completing this worksheet.

Please let us know if you have any questions.