RETURN ALL FINANCIAL APPLICATIONS & DOCUMENTS TO:

St. Mary's Life Center
c/o Amy Brophy-Neilsen, MS, CCC-SLP
2686 Patterson Road Grand Junction CO 81506
(970) 298-6158 FAX (970) 298-6135
amy.neilsen@sclhealth.org

RiteCare
Scottish Rite Masons
Helping Children Communicate
Scottish Rite Foundation of Colorado

SCOTTISH RITE FOUNDATION OF COLORADO
ST. MARY'S LIFE CENTER
Department of Speech Pathology and Learning Services

NEW APPLICATION

The Scottish Rite Foundation, a philanthropy of Scottish Rite Freemasonry in Colorado, was established in 1953 to help families pay for speech-language and learning therapy at Foundation approved programs. Thousands of children and their families have received this help. The Scottish Rite Appraisal Committee at St. Mary's Life Center carefully reviews the financial information that you provide on this application. Please reference the "Terms of Scholarship Assistance" for specific information regarding the Scottish Rite scholarship program.

IDENTIFYING INFORMATION

Child's name:_____ **Birth date:** _____

Father's name:_____ **Mother's name:** _____

Marital status: ___**Married** __**Single** __**Divorced** __**Separated**

Who is the child's legal guardian? _____

Home phone:_____ **Second phone:** _____

Address: _____
(city) **(state)** **(zip code)**

E-mail address: _____

Number of children living in household:_____ **Ages:** _____

Child's Physician_____

RECOMMENDED THERAPY PROGRAM

Has your child received an evaluation for hearing, speech and language, or learning problems?

__Yes ___No If yes, where? _____

Is your child currently receiving therapy for hearing, speech and language, or learning problems?

__Yes ___No If yes, where? _____ **Current Therapist**_____

My child has difficulty with: ☐ **Understanding language** ☐ **Saying the sounds**
☐ **Using words in sentences** ☐ **Stuttering**

Please circle the therapy program your child has been recommended:

Individual **Group** **Individual and Group** **Comments:**_____

MEDICAL INSURANCE

Does your child have medical insurance?___Yes___No If yes, name of carrier: _____

Denied therapy?___Yes___No___Unsure

Does your child currently receive Medicaid?___Yes___No

If yes, please provide the Medicaid state ID number: _____

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FINANCIAL INFORMATION

Please list all sources of income and attach pay stubs showing gross and net pay, and payroll deductions. If you are self-employed, submit copies of your most recent Federal Income Tax Return, including Schedule C.

Father's Employer:_____ How long? _____

Occupation/Position:_____

Father gets paid: **__Weekly (52 times/year)** **__Every two weeks (26 times/year**

__BI-monthly (24 times/year) **__Monthly (12 times/year)**

Amount of take home pay in each check: _____

Mother's Employer:_____ How long? _____

Occupation/Position:_____

Mother gets paid: **__Weekly (52 times/year)** **__Every two weeks (26 times/year)**

__BI-monthly (24 times/year) **__Monthly (12 times/year)**

Amount of take home pay in each check: _____

Other sources of income and monthly amount (e.g., child support, rental income, SSI Disability income):_

_____

Please provide any additional information about your child and family that you would like the Appraisal Committee to consider in reviewing your application.

_____

_____

_____

_____

_____

Families are asked to pay for a portion of their child's therapy program. How much do you feel you can pay, each month, for your child's therapy? _____
(The payment that you are assigned may be different from what you have offered. You are responsible for paying your assigned portion in full each month).

THIS APPLICATION CANNOT BE CONSIDERED WITHOUT PAY STUBS OR FEDERAL INCOME TAX RETURN.

I hereby certify that the above information is correct to the best of my knowledge.

_____ _____

Signature of Child's Legal Guardian **Date**