Suzy Foundation
D.R.E.A.M.S.

Application For Assistance

Suzy Foundation is passionate about helping children with special needs achieve their D.R.E.A.M.S.

Please complete the entire application below and attach the necessary documents.

To Qualify:

1. Child must be 17 years old or younger
2. Include a letter or prescription from the applicant's doctor confirming the need for the requested assistive device or therapy.
3. A copy of parent(s)/guardian(s) most recent Income Tax Return (IRS Form 1040) with copies of all supporting W-2 forms. For your security all information is confidential and treated with the utmost sensitivity. Please black out your social security number. All documents will be shredded once a decision has been made.
4. Letter of denial from parent(s)/guardian(s) insurance company.
5. Your application will be valid one year from its submission date.
6. Incomplete applications will not be accepted. If denied, Suzy Foundation will review your application throughout the year.
7. Suzy Foundation considers each applicant on an individual basis.
8. Please mail completed application to Suzy Foundation, P.O. BOX 24877, Tempe, AZ 85285
9. Must live in the Phoenix/metropolitan area

Please be advised that the Suzy Foundation will directly purchase the assistive device or therapy for the applicant. Please include all of the necessary purchasing information.

Name of Child:

_____

first middle last

Name of Person Completing the Form:

_____

first last

Email Address:

_____

Relationship to Child: _____ **Age of Child:** _____

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Medical Condition of Child:

Please explain how this condition affects the child:

What medical device or therapy are you requesting?

What is the cost of the medical device or therapy?

Please provide purchasing information for this device or therapy:

Is your child currently receiving any of the following services?

☐ Early Intervention/AzEIP ☐ DDD ☐OT ☐PT ☐ Speech Therapy
☐Other (please be specific)

Have you attempted to obtain this device through insurance?

If so, what was the outcome?

If not covered by your insurance, please attach an official letter of denial from your insurance provider.

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What benefit would the medical device provide for the child?

_____

_____

_____

Is there any additional information you wish to share with us in support of your application?

_____

_____

_____

_____

_____

If selected, would you be willing to sign a waiver so that your image and or story can be included on our website and fund-raising information? ☐ Yes ☐ No

How did you hear about us?

_____

_____

Person to contact if selected: Parents/Guardians
Name:_____

Home Address:_____

Phone Number:__(_____)_____

Email:_____

Do you have: ☐ Dr. Prescription ☐ Income Tax Return
☐ Every Question Answered ☐ Insurance Letter