



# Family First

CHILDREN'S FOUNDATION

## Family First Children's Foundation Scholarship Application Form

Our mission is to foster growth and independence by helping children access the therapy services, equipment, and resources they need most. Review the guidelines and requirements carefully to ensure your eligibility.

Submit completed applications by January 1, April 1, July 1, or October 1 to be considered.

### Applicant Information

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Diagnosis/Condition: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email : \_\_\_\_\_  
Home Address: \_\_\_\_\_

### Household Information

Total Number of Household Members: \_\_\_\_\_  
Total Annual Household Income: \$ \_\_\_\_\_

### Funding Request

Total Amount Requested: \$ \_\_\_\_\_

Is this an urgent or time-sensitive request?  Yes  No

If yes, please briefly explain the timeline and reason for urgency:

\_\_\_\_\_  
\_\_\_\_\_

Describe the need and how this funding will support your child's growth and independence. Please be as specific as possible. (Attach additional pages if needed.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was this request submitted to insurance and denied?

Yes  No  Not Applicable

If yes or not applicable, please briefly explain:

\_\_\_\_\_  
\_\_\_\_\_





### Current Therapy Status

Is your child currently receiving therapy services ?  Yes  No

If yes, what type of therapy? And how often does your child attend therapy?

- Physical Therapy \_\_\_\_x per week  Occupational Therapy \_\_\_\_x per week  
 Speech Therapy \_\_\_\_x per week.  Feeding Therapy \_\_\_\_x per week

Are there any out-of-pocket costs associated with your child's therapy?  Yes  No

If yes, please describe:

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Has your child participated in any intensive therapy programs this year?  Yes  No

If yes, please describe (type, location, and approximate dates):

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### Previous Funding

Has your child received prior funding from Family First Children's Foundation?  Yes  No

If yes, please describe what was funded and the year:

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### Eligibility Confirmation

- My child is under 18 years of age.
- My child resides within a 50-mile radius of Lutz, Florida.
- I understand this application must be complete to be reviewed.
- I am providing two (2) professional letters of support in addition to this application.
- I am providing a physician prescription/referral for requests involving medical equipment or intensive therapy programs.
- I am providing an invoice, quote, or cost estimate from provider/vendor.
- I agree to my child being listed as a scholarship recipient on the Family First Children's Foundation website, social media, or promotional materials (first name only, no personal or medical details will be shared without additional consent).

### Acknowledgement & Signature

By signing below, I affirm that the information provided is true and complete. I understand that this application does not guarantee funding, and all decisions are made at the discretion of the Family First Children's Foundation Board.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Submission Instructions

Please submit your completed application and all required documents by email.

Email to: [aleisha@familyfirstctf.org](mailto:aleisha@familyfirstctf.org)