Cole Ohrt Walk Strong Scholarship Application

Date of Application: _____

Patient Name: _____ Date of Birth/Age: _____

Address: _____ Phone Number: _____

Email: _____ Contact Person: _____

Current Insurance: _____

Type of Injury or Disability (Spinal Cord, stroke, traumatic brain injury): _____

Date of Injury or incident: _____

Please provide a brief history of injury or disability: _____

_____

_____

_____

_____

Please provide a description of previous services and rehab you have participated in prior to now, please include dates and where these services were provided: _____

_____

_____

_____

_____

_____

Please state what you hope to achieve from therapy on the LOKOMAT PRO: _____

_____

_____

_____

_____

PO BOX 221 * VICTORIA, TEXAS 77902
TEL: (361) 550-8856

Please list any current services you are receiving (including but not limited to home health, other outpatient rehab services) include length of time, and dates you authorized for: _____

_____

_____

_____

_____

Provide the reason why you are not able to afford therapy service and use of Lokomat Pro. (Such as maximum lifetime benefits achieved, not a covered service on insurance plan, not medically necessary etc.) _____

_____

_____

How do you feel you would benefit from the scholarship? Why do you financially need our assistance?_____

_____

_____

_____

_____

If a minor who is parent/guardian or responsible party?

Name:_____Phone#:_____

I understand that if I am the recipient of a scholarship, Building Kid Steps. LLC/COAL Center will be providing information about the services provided to the scholarship committee that may contain confidential healthcare information such as attendance to therapy, evaluation and recommendations for therapy, progress within therapy, and dates of service. This information is required to be shared with the Cole Ohrt Walk Strong Organization in order to determine the continued need for the scholarship and payment for services.

_____ (authorized party signature) _____ (date)

I understand that the information I am providing is used to determine the need for a scholarship and that this information plus the information provided by the evaluating therapist is how the scholarship funding is determined. Scholarships are provided based on need for services and the need for financial assistance toward quality of life and improved mobility. I understand that any attempt to not share truthful information with the scholarship committee will result in immediate termination of the scholarship and legal action will be taken to recoup the money spent. I understand that I will be provided a set number of walks, for a set frequency and set duration. My attendance of greater than 80% is required to reapply for a new scholarship. I will be required to reapply for additional scholarships at the end of each scholarship period.

_____ (authorized party signature) _____ (date)

For Board Members Only

Start Date: _____
Stop Date: _____
Number of Walks: _____
Approved Amount $: _____
Board Signatures: _____ _____