Medical Care Grant Application

Physician's Certification of Medical Condition

SECTION A – To be completed by child's Parent/Legal Guardian

Parent/Legal Guardian: Please complete "Section A" then give this form to your child's Medical Provider. The Medical Provider **must be an M.D., D.O., O.D., or Au.D.** for hearing-related conditions. Forms completed by a Nurse or Physician's Assistant will not be accepted. The Medical Provider should complete "Section B" then return this form back to the Parent/Legal Guardian. ***This completed form should be submitted to Show Hope by the Parent/Legal Guardian with the Medical Care Grant application***.

Child's First Name ______________________ Last Name ______________________

Child's Date of Birth ______________ Date of Adoption Finalization ______________

Parent/Legal Guardian Name ____

Parent/Legal Guardian Phone __________________ Email ______________________

**Handwritten or digital signature is required.*

Parent/Legal Guardian Signature ________________________ Date ______________

SECTION B – To be completed by child's Medical Provider

Medical Provider: The Parent/Legal Guardian of the child listed above is applying for a Show Hope Medical Care Grant. The Medical Provider filling out this form **must be an M.D., D.O., O.D., or Au.D.** for hearing-related conditions. Forms completed by a Nurse or Physician's Assistant will not be accepted. **Please complete the information below, then return this completed form to the child's Parent/Legal Guardian.**

Provider's Name ______________________________ Credentials ______________

Hospital/Group where child receives care ________________________________

Telephone __________________ Email ______________________________

Street Address ____

City ______________________________ State ________ Zip ______________

Child's Primary Diagnosis ____

Child's Secondary Diagnosis (if applicable) ______________________________

How are the current diagnoses impacting the child's life (check all that apply):

- ❑ Medically
- ❑ Socially
- ❑ Psychologically/Behaviorally
- ❑ Other: ______________________________________

From the following, please indicate the method of care you recommend and describe why it is needed.

**If cognitive rehabilitative therapy is being pursued to help address a known medical diagnosis, as confirmed in writing by a physician, applications will be considered on a case-by-case basis.*

- ❑ Medical and/or Surgical Treatments or Procedures:

- ❑ Rehabilitative Physical or Occupational Therapy:

- ❑ Assistive/Adaptive Devices:

- ❑ Other:

The goal(s) of recommended plan of care:

Has the child previously received these treatments/therapies? Yes No

If yes, has the treatment/therapy been effective and how so?

Additional notes or comments:

**Handwritten or digital signature is required.*

Physician's Signature ____ Date ________________

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