SHOW HOPE

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., or O.D.** For hearing-related conditions, the Medical Provider **must be an Au.D.** 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: _____

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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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