Provider Certification of Medical Necessity

This form must be completed by the child's provider and attached to the online application prior to application submission.

CHILD INFORMATION

Child's Name: _____

Child's Date of Birth: _____

Child's Primary Diagnosis: _____

_____

Child's Secondary Diagnosis (if applicable): _____

Brief Medical History of Child: _____

_____

_____

_____

_____

PROVIDER INFORMATION

Provider's Name: _____

Provider Title: ☐MD ☐DO ☐NP ☐PA ☐AuD ☐DPT ☐MOT ☐SLP ☐DDS/DMD
☐ OTHER: _____

Provider's Phone Number: _____

GRANT REQUEST INFORMATION

Please select the categories in which the grant request is relevant

☐ Clinical ☐ Equipment ☐ Travel

Please complete this section for **CLINICAL & EQUIPMENT** grant requests

Request Summary:
(i.e., 32 sessions of physical therapy; manual wheelchair, etc.)

_____

_____

_____

_____

Goal(s) of Requested Grant:

_____

_____

_____

_____

Please complete this section for **TRAVEL** grant requests
travel anticipated for the next 12 months directly relevant to the child's care

Reason(s)/Necessity for Travel:

_____

_____

_____

Please provide any additional information that can be shared with our funding committee:

_____

_____

_____

_____

_____

Provider Signature _____ **Date:** _____