

Special Kids Health & Wellness Center, Inc.

Application for Services

Your Child and You

Name of Child/Participant: _____

Address of Participant: _____

Phone of Participant: _____

Your Name (if different): _____

Address (if different): _____

Phone (if different): _____

Special Kids Services

What Programs are you applying for?

Please describe what benefits you hope to receive from the programs:

Special Needs Child

If participant is certified as a special needs child or young adult, please describe the treatment, modality, and diagnosis. Please attach supporting documentation.

Scholarship Services

Are you applying for a reduced fee or free services? Briefly explain your circumstances here.

You must also attach a copy of your monthly budget and supporting documentation, including pay stubs, receipts for therapy methods and medical services, and any other evidence of costs incurred to support your child's well-being.

Determination of free or low cost services will be made by a committee of the Board of Special Kids. You will be contacted once a decision has been made.