Florida Elks
CHILDREN'S THERAPY SERVICES
Mobile In-Home Therapy since 1999

P.O. Box 49, Umatilla, FL 32784-0049 | 800-523-1673 | www.elkstherapy.com | cgallant@floridaelkscts.org

Dear Parent/Legal Guardian,

Thank you for your interest in the Florida Elks Children's Therapy Services! Florida Elks Children's Therapy Services is a program that offers free in-home occupational and physical therapy to Florida children. These services are provided by one of our 30 licensed therapists, employed by the Florida Elks, who provide child centered treatment and family education throughout the entire state. These services are necessary in the home because of the absence of these services locally or because of the child being medically homebound.

Eligibility for treatment will be based on several factors including medical needs and other criteria, such as but not limited to:

1. The child must be a resident of Florida
2. The child must be between the ages of birth and 18 years of age
3. The child must have a medical condition necessitating Physical or Occupational Therapies
4. The patient must have rehabilitative potential
5. The patient must have financial need for free services

The Application is fillable (can be completed on a computer or smart phone) and emailed to cgallant@floridaelkscts.org. Applications must be filled out entirely. Incomplete applications will not be accepted and will result in delays of processing. Completed Applications can be:

- **Emailed:** cgallant@floridaelkscts.org
- **Faxed:** 239-309-0209
- **Mailed:** P.O. Box 49, Umatilla, FL 32784
- **Given to FECTS Therapist**

At any time, if you have questions on the services provided or Application, please do not hesitate to call our office at 800-523-1673.

Thank you,

Colleen Gallant

Colleen Gallant
Florida Elks Children's Therapy Services Director
cgallant@floridaelkscts.org

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OFFICE USE ONLY	
Received Date:	Approved Date:
Referred to (Therapist):	

Application for Services

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Child's Information

Name: _____ (First) _____ (Middle) _____ (Last)

D.O.B: _____ (MM/DD/YYYY) Age: _____ ☐ Years ☐ Months Sex: ☐ MALE ☐ FEMALE

Address: _____ City: _____ Zip Code: _____

FECTS Services Applying for: ☐ Physical ☐ Occupational

Has the Child received FECTS services before? ☐ Yes ☐ No If yes, when? _____

Who referred you to FECTS? _____

Name of Child's School: _____ Grade: _____

Medical Information

Child's Diagnosis/Therapeutic Concerns:

_____

_____

Is the Child currently receiving any other therapies? ☐ Yes ☐ No

If yes, what kind? _____

_____

Child's Physician: _____

Address: _____ City: _____

Zip Code: _____ Phone: _____ Fax: _____

Child's Health Insurance? ☐None ☐Private ☐Medicaid ☐Other: _____

Parent/Legal Guardian Information

Parent/Legal Guardian #1

Name: _____ (First) _____ (Last) D.O.B. _____ (MM/DD/YYYY)

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

Does Child live with? ☐ Yes ☐ No

Relationship to Child: ☐Parent ☐Grandparent* ☐Foster/Adoptive* ☐Other*: _____

*Please provide any necessary documents to show Guardianship

Employer Name: _____ Phone: _____

Parent/Legal Guardian #2

Name: _____ (First) _____ (Last) D.O.B. _____ (MM/DD/YYYY)

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

Does Child live with? ☐ Yes ☐ No

Relationship to Child: ☐Parent ☐Grandparent* ☐Foster/Adoptive* ☐Other*: _____

*Please provide any necessary documents to show Guardianship

Employer Name: _____ Phone: _____

Parent/Legal Guardian #3 (if applicable)

Name: _____ (First) _____ (Last) D.O.B. _____ (MM/DD/YYYY)

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email Address: _____

Does Child live with? ☐ Yes ☐ No

Relationship to Child: ☐Parent ☐Grandparent* ☐Foster/Adoptive* ☐Other*: _____

*Please provide any necessary documents to show Guardianship

Employer Name: _____ Phone: _____

Financial Information

What is your household's total combined yearly income? ☐$0 - $10,000 ☐$10,000 - $20,000 ☐$20,000 - $30,000 ☐$30,000 - $40,000 ☐$40,000 - $50,000 ☐$50,000 - $75,000 ☐$75,000 & over

Tell Us Your Story

How can FECTS help?

Acknowledgement

I certify that the provided information on this application is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification by the Florida Elks Children's Therapy Services.

Parent/Legal Guardian Signature: _____ **Date:** _____

THERAPIST USE ONLY

Date: _____ Therapist Name: _____

Notes:

Therapist Signature: _____ **Date:** _____

Approved ☐ **Denied** ☐

Director Signature: _____ **Date:** _____