KRIS' CAMP THERAPY INTENSIVE PROGRAMS
APPLICATION FOR FINANCIAL ASSISTANCE / SCHOLARSHIP

CAMP LOCATION & DATE FOR WHICH YOU ARE APPLYING: _____

TODAY'S DATE:

CHILD'S NAME: D.O.B.:

PARENT (S) /GUARDIAN (S) NAME:

ADDRESS

HOME PHONE: WORK:

MOBILE/OTHER: EMAIL:

HAS YOUR CHILD / FAMILY ATTENDED KRIS' CAMP BEFORE?

NO ☐ YES ☐ IF SO, WHEN?:

HAVE YOU RECEIVED FINANCIAL ASSISTANCE BEFORE?

YES☐ NO ☐

PROJECTED TOTAL COST FOR KRIS' CAMP (INCLUDE LODGING AND TUITION; DO NOT INCLUDE FOOD OR GAS): $_____

WHAT OTHER SOURCES OF FUNDING HAVE YOU APPLIED FOR TO HELP IN YOUR COSTS TOWARD KRIS' CAMP THIS YEAR? (PLEASE NOTE THAT EFFORTS TO RAISE OUTSIDE FUNDS IS VIEWED FAVORABLY BY THE SCHOLARSHIP COMMITTEE):

ORGANIZATION/EVENT	**AMOUNT EXPECTED/APPROVED**
1. _____	$_____
2. _____	$_____
3. _____	$_____

TOTAL AMOUNT OF SCHOLARSHIP YOU ARE REQUESTING FROM KRIS' CAMP: $_____

HOW DO YOU FEEL YOUR CHILD AND FAMILY WILL BENEFIT FROM KRIS' CAMP?

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INCOME INFORMATION (PLEASE USE GUARDIAN INFORMATION IF FATHER/MOTHER NOT APPLICABLE):

	PARENT/GUARDIAN I	PARENT/GUARDIAN 2
Name:	_____	_____
Address:	_____	_____
	_____	_____
Phone:	_____	_____
Employer:	_____	_____
Position:	_____	_____
Work Phone:	_____	_____

Income **Before Taxes** (please indicate if weekly, monthly, bi-monthly):

_____ _____

Other Income: _____ _____

Gross Annual Income last 2 calendar years:

Current year:_____ _____

Last year:_____ _____

Please list assets and other income sources:

*****YOU MUST attach a copy of your most current tax return. This is required to verify income information, as scholarships decisions are based on income. Your application will NOT be considered without proof of income. You may attach additional documentation if your income situation has changed dramatically since your most recent tax return.***

Monthly Expenses (If these add up to more than your stated income, please explain):

RENT: _____ PHONE:_____
MORTGAGE PAYMENT:_____ TRANSPORTATION:_____
MONTHLY FOOD:_____
CAR PAYMENT:_____
UTILITIES: _____
OTHER EXPENSES, PLEASE SPECIFY:_____

MEDICAL EXPENSES:

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1. THERAPY EXPENSES (monthly) such as PT, OT, MT, SPT (please list):

2. OTHER EXPENSES FOR CHILD: _____
EDUCATIONAL : _____
ADAPTIVE EQUIPMENT:_____
OTHER,PLEASE SPECIFY:_____

3. Other medical bills, please list to whom, for what and total owed monthly:
_____

HEALTH INSURANCE:
DO YOU HAVE MEDICAL INSURANCE? YES____ NO_____
IF YES, COMPLETE THE FOLLOWING:
NAME OF INSURANCE CARRIER:_____

DOES YOUR INSURANCE PAY FOR THERAPY EXPENSES? PLEASE SPECIFY

_____

_____

WHAT IS YOUR INSURANCE DEDUCTIBLE PER YEAR?:_____

WHAT IS YOUR COST FOR INSURANCE COVERAGE / MONTH?:_____

INSURANCE PAYS WHAT % OF YOUR CHILD'S MEDICAL EXPENSES?:_____

HOW MUCH OUT OF POCKET EXPENSE DO YOU PAY BEFORE YOUR INSURANCE PAYS 100% OF YOUR MEDICAL EXPENSES?:_____

All information gathered in this application process will be kept confidential. Additional information may be required for a final decision regarding financial assistance for Kris' Camp.

Person completing this form_____

Signature_____

Date _____

Please attach a copy of your most current tax return as verification of income. This is required to process this application, as scholarships decisions are based on income; APPLICATIONS SUBMITTED WITHOUT PROOF OF INCOME CANNOT BE CONSIDERED.

Please mail this scholarship application to Kris' Camp. Packet should be postmarked on or before MARCH 30TH.

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Mailing address:

Kris' Camp
1132 Green Hill Trace
Tallahassee, FL 32317

Or email to: kberger62@gmail.com