Buckaroo Foundation

**APPLICATION FOR FINANCIAL ASSISTANCE**

Name of patient: _____

Name of Parent/Guardian if patient is under 18: _____

Address: _____

City/State/Zip:_____

Home Phone: _____Cell Phone:_____

E-mail address: _____

O CHECK HERE IF YOU ARE APPLYING FOR RENEWAL Reason for request of financial assistance:

_____

_____

_____

_____

Benefits you have experienced as a result of physical therapy on horseback:

_____

_____

_____

_____

Type of assistance requested:

O 50% THERAPY SCHOLARSHIP O 100% THERAPY SCHOLARSHIP

O EQUIPMENT TYPE: _____ EQUIPMENT COST: _____

O Other: _____

* Please note that assistance is restricted to families experiencing financial hardship. By signing below, you certify that the information on this application is complete, true, and submitted for the purpose of obtaining financial assistance due to financial hardship. You acknowledge that you are aware that the Board of the Buckaroo Foundation, Inc. reserves the right to request copies of your past two years worth of tax returns.

_____ _____

Patient (or Guardian if patient is under 18) Application Date

Please mail your application to:

Buckaroo Foundation, Inc. 1204 Shelton Beach Rd Ste 3 #307 Saraland, AL 36571

**BOARD USE ONLY: Date Received:_____ Date Approved: _____**