BUCKAROO FOUNDATION GRANT APPLICATION

NAME: _____
ADDRESS:_____
_____
PHONE:_____
EMAIL:_____
COUNTY OF RESIDENCE:_____
APPLICANT'S NAME:_____
APPLICANT'S BIRTHDAY: _____
APPLICANT'S AGE:_____
DIAGNOSIS:_____
THERAPY CLINIC:_____
DATE OF SERVICE:_____
TOTAL AMOUNT OF BILL:_____
INSURANCE PROVIDER OF PATIENT _____
HAS THIS SERVICE BEEN SUBMITTED TO INSURANCE?_____
WAS THIS SERVICE DENIED OR NEVER COVERED?_____
DOES THE PATIENT HAVE SECONDARY INSURANCE?_____
WAS THIS SERVICE SENT TO A SECONDARY INSURANCE?_____
WAS THIS DENIED/NOT COVERED BY SECONDARY INSURANCE?_____

**PLEASE INCLUDE PROOF OF DIAGNOSIS FROM A MEDICAL PROVIDER, THERAPY NOTES AND BILL FROM DATE OF SERVICE, COPY OF INSURANCE CARD, AND COPY OF GUARDIANS ID.

****PLEASE MAIL TO: BUCKAROO FOUNDATION**
30941 MILLS LANE SUITE G-336
SPANISH FORT, AL 36527
ALL APPLICATION MUST BE POSTMARKED BY THE 20th OF EACH MONTH

****EMAIL: BUCKAROOFOUNDATION@GMAIL.COM**

**APPLICANTS ACKNOWLEDGE AND AFFIRM THAT ALL INFORMATION PROVIDED HERE IN SHALL BE ACCURATE AND HONEST TO THE BEST OF THEIR KNOWLEDGE, WILL NOT CONTAIN ANY INFORMATION WHICH IS FRAUDULANT, DISHONEST, OR OMIT ANY MARITAL INFORMATION REQUESTED, THAT ALL INFORMATION PROVIDED WILL BE ACTED ON AND RELIED UPON BY COMPANY AND IS REQUIRED TO BE VERIFIED BEFORE ANY FUND, RESOURCES OR ASSISTANCE WILL PROVIDED TO APPLICANT BY THE COMPANY.

BOARD USE ONLY: DATE RECEIVED_____ DATE APPROVED_____