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:

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

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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. 7371 Saluda Blvd, Spanish Fort, AL 36527

BOARD USE ONLY: Date Received:____________ Date Approved: _____________