HOPE
Helping Outcomes for Parents of Exceptional children

Family Application

Parent/Guardian Names: _____

Address _____ City _____ State _____ Zip _____

County: _____ Phone: _____ Cell: _____

Email address: _____

Child's Name: _____ Child's Primary Diagnosis: _____

Can the diagnosis above be verified? If so, how? _____

Does your child have a Case Manager? If so, who? _____

Does your child have Direct Care Support? _____

What is the family income after taxes? _____

Who lives in the home? _____

List names and ages of individuals in household: _____

Is this your first request with HOPE? If no, what was the result of your initial request? _____

Listed below are the current services provided. Please identify services that interest you.

___ Movie ___ Spa Packages

___ Dinner ___ 3day/2night get-a-way

___ Theater ___ Sporting events

Is your child/family in need of assistance with accessing any of the following services?

____ Disability Services

____ Medicaid

____ Therapy Services

____ Marriage/Couples/Family Therapy

By signing below, you are stating the information is accurate to the best of your knowledge, that you give HOPE staff permission to verify the information provided, and also give HOPE staff the ability to discuss your application amongst the HOPE application committee.

Signature: _____ Date: _____

Official use: Date Received: _____ Date Reviewed: _____ Approval/Disapproval: _____

Applicant notification: _____