Your Excuse is Invalid NFP (501c-3)
Equipment Scholarship/Grant Application

Applicant Name: _____ Date of Birth: _____

School Attended and Grade Level if applicable: _____

Work location and duties if applicable: Type text here _____

If recipient is under the age of 18,
Guardian Name: _____
Relationship to Applicant: _____

Contact Information:
Address: _____
City/Town: _____
State: _____
Phone Number #1 (Guardian if under 18): _____
Phone number #2 (Applicant): _____

List sports and/or additional physical activities that applicant currently participates in:

Medical providers you are currently working with (i.e., physician, physical therapist chiropractor, prosthetist) and their contact information:

_____

What is the date of your injury or onset of impairment?_____

What is the nature of your injury or impairment? Please describe any medical diagnosis you have received first. Next, describe any other related diagnoses or other co-morbidities/ medical conditions that impact your overall health and function.

Medical history:

What is your current level of Physical Disability or Impairment? Please describe current limitations including difficulties with any movement or specific task. Also describe any

adaptations your have made to accommodate your limitations. Finally, please list any assistive devices or medical equipment you are currently using.

Physical Impairments: Adaptations: Medical Equipment, assistive devices used currently:

Are your current pieces of medical equipment or assistive devices meeting your needs? If not, please describe what equipment you need and and what current limitations the equipment would meet.

Equipment Need:

Please inform us of any attempts to get this equipment/device using your traditional insurance. Have options for coverage been exhausted through the current health care team and insurance provider?

Description of efforts to get this equipment/device

What are your goals regarding physical activity and/or sports participation?

How would your request of medical equipment or assistive devices help you reach these goals?

Goals

Are you willing and able to return to any necessary health care professional to help you utilize new equipment to the best of your ability? Yes/No
If No, please explain:

Please share anything you would like to with us regarding your current family or financial situation that makes it difficult to cover the costs of medical needs or reach goals.

HIPAA Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____. **OR**

b. ☐ all past, present, and future periods. **3. Extent of Authorization**

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR b. □ I authorize the release of my complete health record with the exception

of the following information: □ Mental health records

□ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify):

_____

4. This medical information may be used by the person I authorize to

receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative Printed name of patient or personal representative and his or her relationship to patient Date

Photography Release Form for Minors (Under 18 Years of Age)

This Photography release contract for Your Excuse is Invalid NFP allows for the use of photographs of _____ to be used for fliers, newsletters ,online publications, website, social media and all other promotional purposes. I understand that Your Excuse is Invalid NFP, Your Excuse is Invalid Motivational Speaking, and No Excuses Adaptive sport and Training have my permission to utilize photographs as stated above. I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

Parent/Guardian Signature(S)

_____ Date:_____

_____ Date:_____

Parent/Guardian Name(s)

_____

_____

Child's Name:_____
Address:_____
Phone Number:_____

Photography Release Form for Adults (Over 18)

This Photography release contract for Your Excuse is Invalid NFP allows for the use of photographs of _____ to be used for fliers, newsletters ,online publications, website, social media and all other promotional purposes. I understand that Your Excuse is Invalid NFP, Your Excuse is Invalid Motivational Speaking, and No Excuses Adaptive sport and Training have my permission to utilize photographs as stated above. I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

Signature:_____Date:_____

Name:_____

Address:_____

Phone Number:_____