Client Name ____________________________

*Date*____________________________

90 Day Scholarship Application

PLEASE READ THIS ENTIRE FORM CAREFULLY AND RETURN COMPLETED FORM AND PROOF OF INCOME AT LEAST 5 WORKING DAYS PRIOR TO YOUR FIRST APPOINTMENT. THIS MUST BE APPROVED IN ADVANCE IF YOU ARE TO RECEIVE REDUCED FEES.

We're pleased that you're considering the valuable services offered by the clinical staff at Challenge Center. All services at Challenge Center are offered at competitive pricing found within our industry. What sets Challenge Center apart are programs where low-income participants who are living with physical disability can apply to qualify for reduced fees for services. The Challenge Center provides these discounted rates based on level of income as well as level of disability. The following application asks for both financial information and information about your physical disability.

Challenge Center must raise contributions and donations to pay for costs not covered by fees. To that end, we ask each client who would like to be considered for a reduction in fees to work with us to find creative ways to help raise funds to cover their specific costs. Family members, church groups or service clubs are just some of the resources that have helped our clients with sponsorship. We're including a form letter that you can use as an example of how you might approach a potential donor on your behalf. Please discuss this with our business office.

Proof of income is necessary for any consideration of reduced fees. We require (1) a copy of the first page of your latest federal tax return, (2) a copy of your most recent bank statement showing income (please black out account numbers) and (3) current (at least one month) copies of pay stubs or other sources of income. All three forms of information must be submitted to be considered for scholarship. This application, if approved, will provide an initial 90 days of service at reduced fees. Application and continuance for financial aid are reviewed every three months based on clinical staff progress notes and approval of a new application for reduction in fees.

To be eligible to have your 90 Day Scholarship renewed, we ask that you strictly follow our no-show and cancellation policy. You must, of course, be present to receive the benefit of our services and missed appointments are costly to the Center. Clients who are not in compliance with the policy will not be eligible to renew a reduced fee scholarship. A copy of our no-show and cancellation policy is attached for your review.

Any financial information you provide will remain confidential, although your information might be used in reporting anonymous demographic data to funding sources. We look forward to serving you and thank you for your commitment to improving your health and quality of life.

*Please call ahead to confirm the status of your application before your first appointment. Payment in full is due at the time of services.

FINANCIAL INFORMATON

Annual Income of Participant (SELF) $____

Employed _________ Unemployed _________ Since _________ Retired _________ Since _________

Current Source of Income (Please list all sources such as SSI, Child Support, Alimony, Interest)

____ Monthly Gross Income ______________

____ Monthly Gross Income ______________

____ Monthly Gross Income ______________

Total Monthly Income _______________

Current Employer ____Since ________________

Address ____Phone________________

Prior Employer ____from __________ to __________

Annual Income of SPOUSE $____

Employed _________ Unemployed _________ Since _________ Retired _________ Since _________

Current Source of Income (Please list all sources such as SSI, Child Support, Alimony, Interest)

____ Monthly Gross Income ______________

____ Monthly Gross Income ______________

____ Monthly Gross Income ______________

Total Monthly Income _______________

Current Employer ____Since ________________

Address ____Phone________________

Prior Employer ____from __________ to __________

Own Home ______________Since _______________ Rent Home _______________Since _________

With whom do you (participant) live? ____

How many people live in your household?____

How many people are employed? ____

Income of Household $____

Source of Household Income____

Name, relationship and age of dependents living at home:

Name ______________________________ Relationship__________________ Age ________________

Name ______________________________ Relationship__________________ Age ________________

Name ______________________________ Relationship__________________ Age ________________

Name ______________________________ Relationship__________________ Age ________________

Are there other circumstances around housing and dependents we should consider on your behalf?
____
____
____

Assets: Please describe assets such as checking and savings account balances, trusts, property (other than residence above), automobiles, investments and any asset that provides you with greater financial strength. Please include settlements related to your disability, and attached verification copies.

Checking) Bank Name___________________________________ Balance $ ___________________
Savings) Bank Name____________________________________ Balance $ ___________________
Trust Accounts) Bank Name_______________________________Balance $ ___________________
Settlement) ____ Value $___________________
Other ____ Balance/Value $ _____________

QUALIFYING DISABILITY FOR FEE REDUCTION

The Challenge Center provides services at a reduced fee to low income individuals who meet our definition of having a permanent or chronic physical impairment(s) that causes a disability.

The following are the definitions used to define a physical disability.

Physical Impairment - any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin or endocrine.

A Physical Impairment is not necessarily a disability.
To be considered **Physically Disabled** an individual must show that his or her **physical impairment** substantially and actually limits one or more of his or her major life activities.

QUESTIONAIRRE

1) Please list any/all diagnosis you have been given by a licensed physician

____
____
____
____
____
____
____
____

2) Please list any/all **physical impairments** you currently have:

☐ High or Low Tone ☐ Poor coordination ☐ Ataxia ☐ Hemiplegia

☐ Paralysis ☐ Limb loss ☐ Weakness ☐ Shortness of Breath

☐ Angina ☐ Arrhythmia ☐ Poor endurance ☐ Numbness ☐ Contractures

☐ Pain (location/severity)____

☐ Other (please list)____

3) Please detail the activities that your physical impairment substantially limits or prevents you from accomplishing – which activities can you **not** do?

☐ Dressing ☐ Toileting ☐ Eating ☐ Feeding Yourself ☐ Sitting Up

☐ Bathing/Showering ☐ Transferring ☐ Standing ☐ Lifting 3lbs

☐ Standing with assistance ☐ Cooking ☐ Reaching

☐ Walking -

How far can you walk using any assistive device (walker, cane, brace etc.)?

_________ feet or ____________blocks

What device(s) do you use to move about? _________________________

Do you need help from another person to walk? _________

How much assistance do they provide?____________________________

Can you manage stairs?______ Steps?________ Curbs?_____________

Which impairment most limits your walking?_________________________

Other comments____

4) Please share any other relevant information we may have missed.

____
____
____

If there is any other information you want us to consider, please submit your information in letter form and attach it to the completed packet. Note here that you've attached that information for our review. ____

The undersigned hereby states that all the above information is true and will provide documentation as required. Undersigned also understands that Challenge Center reserves the right to discontinue financial aid if poor attendance or unwillingness to participate is observed by clinical staff.

____ Date__________________
Signature of Participant or Financially Responsible Agent (Please sign and date before submitting.)

CHALLENGE CENTER ABSENTEE, NO SHOW, & CANCELLATION POLICY

Challenge Center's valuable and unique services rely on member fees as a portion of the income needed to cover program costs. We understand that our member's schedules sometimes vary. However, prolonged absenteeism, frequent "no shows" and cancellations leave program sessions unfilled, income irregular, and our services inaccessible to those who are on our waiting list. To help us better serve our clients, Challenge Center has established the following **Absentee, "No Show," and Cancellation Policy:**

Assisted Fitness Clients:

- To remain "active," absent members must continue to pay their monthly fitness dues.
- Upon request, **time slots can be held for up to one month per /year for medical or personal reasons, with payment of dues**. *In consideration of our staff,* ***Please notify us ahead of time of any planned absence.***
- In order to meet the needs of the entire community, we regret that the Challenge Center is unable to accommodate absences of more than one month per /year. **Members who must leave the program for more than one month due to medical or personal reasons will be moved to the program waiting list.** Return to any Challenge Center program will require re-evaluation along with medical clearance. We will make every effort to facilitate your quick return to the program, but unfortunately, we cannot guarantee the availability of previous time slots.
- Because our fitness trainers need to manage multiple fitness clients during any given time period, arriving on time is greatly appreciated. Please be aware that **if you are in need of assistance with your exercise program, late arrival for scheduled workouts or training may require modification to your exercise program for the day.**

Physical Therapy Patients & CFES Clients:

- Physical Therapy and CFES appointments are to be scheduled within specific time slots.
- If you cannot attend a scheduled appointment, please make a courtesy call and cancel your appointment at least **24 hours in advance**.
- At Challenge Center's discretion**, two or more "no shows" (missed appointments without calling to cancel) in a month** will likely result in (**1**) any remaining scheduled appointments to be cancelled leaving this time available for others, (**2**) collection of payment for each appointment missed, and **(3)** payment for future services in advance on the day services are delivered.
- At Challenge Center's discretion, **greater than two cancelled appointments in a month** will likely result in (**1**) collection of payment for each appointment missed in order to keep any remaining scheduled appointments and (**2**) payment for services in advance on the day services are delivered. **If cancellations are due to medical reasons, documentation from your doctor will assist in avoiding cancellation charges.**
- Return to any Challenge Center program will require re-evaluation along with medical clearance. We will make every effort to facilitate your quick return to the program, but unfortunately, we cannot guarantee the availability of previous time slots.
- Because each scheduled appointment provides approximately one full hour of clinical attention***, late arrival beyond 15 min. may require rescheduling or modification of the day's treatment plan.***

CLIENT LETTER SAMPLE

This is an example of a letter that has worked for many of our members who have sought help from corporate friends, churches and service clubs in covering the remaining costs of therapy not paid by the member's reduced fees. Personalizing this is important in making this reflect your own experience. Let us know how we can help.

I have something to share with you- a decision I've made to (return to physical therapy, begin a specialized fitness program adapted to my needs) so that I can address ______________________________. As you might already know, I've been dealing with ____ and have found a facility, the Challenge Center that can help. With a plan of care designed specifically for me by my therapist, along with my physician's encouragement and approval, I'm going to begin (treatment, training) in the coming weeks. My goal is to ____, improving my (function, ___________________), wellness and quality of life.

The Challenge Center is a unique facility in San Diego whose business model is designed to provide skilled physical therapy and specialized fitness training for persons with disability on a modified fee scale. The Center's operating costs are no different than other facilities- but their focus on client need, as a community based not-for-profit, is definitely different. Fundraising is a part of everyday business to ensure that the Center's skilled staff can provide therapy training services to those who cannot afford the cost themselves or who are not insured for these beneficial services. Because of my circumstances, I qualify for reduced fees for an initial period of 90 days. At the end of the first 90 days, my therapist and I will re-evaluate my progress and my plan to move forward.

I'm writing today to ask that (you, the church, our organization) consider sponsoring a portion of the cost of my treatment/services. The fees for _______________ for the first 90 days will be $____________. My share of cost, based on my financial circumstances, will be $____________. I'm doing what I can to help the Challenge Center to identify other sources of funding that can help cover the costs of my _________________. May we rely on your help to cover some of these costs?