Suzy Foundation
D.R.E.A.M.S.

Application For Assistance

Suzy Foundation is passionate about helping individuals with special needs. Please complete the entire application below and attach the necessary documents.

To Qualify:

1. Include a letter or prescription from the applicant's doctor confirming the need for the requested assistive device or therapy.
2. A copy of parent(s)/guardian(s) most recent Income Tax Return (IRS Form 1040) with copies of all supporting W-2 forms. For your security all information is confidential and treated with the utmost sensitivity. Please black out your social security number. All documents will be shredded once a decision has been made.
3. Letter of denial from parent(s)/guardian(s) insurance company.
4. Your application will be valid one year from its submission date.
5. Incomplete applications will not be accepted. If denied, Suzy Foundation will review your application throughout the year.
6. Suzy Foundation considers each applicant on an individual basis.
7. Please mail completed application to Suzy Foundation, P.O. BOX 24877, Tempe, AZ 85285 or submit online
8. Must live in the Phoenix/metropolitan area

Please be advised that the Suzy Foundation will directly purchase the assistive device or therapy for the applicant. **Suzy Foundation will NOT reimburse services rendered or devices previously purchased**. Please include all of the necessary purchasing information.

Name of Individual : **Date:**

first middle last

Name of Person Completing the Form:

first last

Email Address:

Relationship to Individual: **Age of Individual:**

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Medical Condition of Individual:

Please explain how this condition affects the individual:

What medical device or therapy are you requesting?

What is the cost of the medical device or therapy?

Please provide purchasing information for this device or therapy:

Is the individual currently receiving any of the following services?

☐ Early Intervention/AzEIP ☐ DDD

*If your child is not receiving any of the above service(s) have you applied?

◯ Yes ◯ No

If yes, what was the outcome of your application?

Is your child currently receiving any of the following therapies?

☐ OT ☐ PT ☐ Speech Therapy ☐ Other (please be specific)

If your child receives OT, PT, or speech therapy, and the device or service you are requesting will improve his or her progress within that therapy: Please attach a letter from your child's therapist detailing your child's current limitations and progress.

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Have you attempted to obtain this device through insurance? ◯ Yes ◯ No

If yes, what was the outcome?

If not covered by your insurance, please attach an official letter of denial from your insurance provider.

What benefit would the medical device provide for the individual?

Is there any additional information you wish to share with us in support of your application?

If selected, may Suzy Foundation use the individual's image and story on our website and fund-raising information? ◯ Yes ◯ No

How did you hear about us?

Person to contact if selected: Parents/Guardians Name:

Home Address:

Phone Number: ☐ Preferred Method of Contact

Email: ☐ Preferred Method of Contact

Did You Attach? ☐ Dr. Prescription ☐ Income Tax Return ☐ Insurance Denial Letter ☐ Letter from OT, PT or Speech Therapist ☐ Every Question Answered