Ref:

CANDIDATE FOR SCHOLARSHIP

LONE STAR PARALYSIS FOUNDATION - CONFIDENTIAL

Name of Candidate_____ Age _____ Sex _____ Yrs with Condition _____

Contact Cell _____ Email _____

How did you hear from us?_____Referred by _____

Treating Physician Specialty _____ Email _____

Name _____ Ph # _____ Fax# _____

Brief Clinical Summary of Candidate _____

_____

_____

_____

Candidate's Current Physical Status_____

_____

_____

_____

Recommendation for rehab services_____

_____

_____

Need Rating (from 1 to 5, 5 being the highest) _____ Signature _____ Date _____

Treating Therapist

Therapist Name _____ Ph # _____ Email _____

Spero Rehab_____ Easter Seals_____ Therapy Needed: PT ____ OT____ (100 Sessions @ $100/hr + Evaluation)

Insurance: _____ None ____ Exhausted ____ DARS /TWS explored : Yes ____ No ____ Other _____

Minor Equipment Needs: _____ cost $_____ Transportation needs: _____cost $_____

Current Assessment of Candidate _____

_____

_____

_____

_____

Summary of Proposed Rehab Program _____

_____

_____

_____

_____

Expected Results from Rehab Program _____

_____

_____

_____

_____

Other Notes: _____

_____

Recommendation _____

_____

Progress reports are needed by treating Therapists every 30 days to the Committee

Need Rating (from 1 to 5, 5 being the highest) _____ Signature _____ Date _____