FOUNDATION FOR AUTISM CARE, EDUCATION, AND SERVICES
(F.A.C.E.S.)
Ein#20-4767823

Application for Scholarship Award

Dear Applicant:

The Foundation for Autism Care, Education, and Services (F.A.C.E.S.) is a non-profit, 501(c)3 foundation. F.A.C.E.S. is dedicated to raising funds to directly support and promote Applied Behavior Analysis (ABA) Therapy, training, and treatment for children with Autism Spectrum Disorder (ASD).

Applicants who will be considered for a scholarship must meet the following criteria:

- **Individuals** applying for a scholarship must have a child or be the legal guardian of a child formally diagnosed with ASD, have confirmed an opening for placement with the ABA Therapy Center they would like their child to attend (must indicate first date of enrollment), or be currently enrolled at an ABA Therapy Center. Individuals must be seeking a scholarship on behalf of the child because they cannot financially afford ABA Therapy**.** ***F.A.C.E.S. will not consider an application for a child unless the parent or guardian has sought health insurance coverage for the child and still needs financial assistance.*** *F.A.C.E.S. will not award scholarships for testing, evaluations, and/or other diagnostic purposes.*
- **Therapy Centers** applying for a scholarship must use ABA as the main therapeutic modality for children with ASD and must be requesting financial assistance solely for the cost of materials used directly for ABA Therapy within the center requesting funds.
- **Therapists, Students, and/or Parents** applying for a scholarship must be requesting financial assistance to further their education and/or training in ABA Therapy.

Please complete the attached application in its entirety and provide all requested documents. *Please pay particular attention to the request for health insurance, tax returns, monthly budget, financial assets statement (part 2 of application) and income information.* Incomplete applications will not be considered. Applicants need only to return the portion of the application pertaining to their request. A checklist is provided on page 7 to help ensure you application is complete. Please mail the completed application and all requested documents to:

F.A.C.E.S.
C/o KJ Wittmann
8823 Tweedbrook Drive
Spring, TX 77379

Thank you for your interest in F.A.C.E.S.

Sincerely,
F.A.C.E.S. Board of Directors

F.A.C.E.S. SCHOLARSHIP APPLICATION

FOR INDIVIDUALS SEEKING FINANCIAL ASSISTANCE FOR THE TREATMENT OF THEIR CHILD

CHILD'S LEGAL NAME: _____

CHILD'S DATE OF BIRTH: _____

ABA TREATMENT CENTER YOUR CHILD CURRENTLY ATTENDS OR PLANS ON ATTENDING:

_____

**Current enrollment or an opening for placement will be confirmed with the ABA Treatment Center prior to scholarship consideration.*

CONTACT PERSON AT ABA TREATMENT CENTER: _____

PHONE NUMBER FOR ABA TREATMENT CENTER: _____

CONTACT PERSON REGARDING INSURANCE: _____

CONTACT PERSON FOR CLIENT INTAKE SERVICES: _____

COST OF ABA THERAPY PROGRAM PER MONTH: _____

SCHOLARSHIP AMOUNT REQUESTED: _____

AMOUNT FAMILY IS ABLE TO CONTRIBUTE PER MONTH TOWARD ABA THERAPY PROGRAM:

_____

**Scholarships are awarded in a manner that is most fiscally responsible for F.A.C.E.S. Scholarships may be awarded quarterly and/or annually to cover the maximum out of pocket deductible if the child's therapy is covered by insurance. This decision is made on a case by case basis by the F.A.C.E.S. Board of Directors.*

Child's Primary Insurance Plan: _____

Subscriber's Name: _____

Group Number: _____ ID Number: _____

Subscriber's Date of Birth: _____ Effective Date of Insurance Coverage: _____

Subscriber's Employer: _____

Amount insurance plan is contracted to pay toward therapy: _____

If the answer is NONE, reasons for denial of insurance coverage: _____

MOTHER'S FULL NAME: _____

MOTHER'S PRIMARY PHONE NUMBER: _____

MOTHER'S SECONDARY PHONE NUMBER: _____

MOTHER'S EMAIL ADDRESS: _____

MOTHER'S EMPLOYEER: _____

MOTHER MUST PROVIDE TAX RETURNS FOR THE LAST TWO YEARS

FATHER'S FULL NAME: _____

FATHER'S PRIMARY PHONE NUMBER: _____

FATHER'S SECONDARY PHONE NUMBER: _____

FATHER'S EMAIL ADDRESS: _____

FATHER'S EMPLOYEER: _____

FATHER MUST PROVIDE TAX RETURNS FOR THE LAST TWO YEARS

Please provide or attach a brief statement explaining why your family is requesting a scholarship from F.A.C.E.S.

_____
_____
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If the child is insured, please provide a copy of the SBC (Summary of Benefits and Coverage), and/or the therapy center cited in this application regarding cost/payment for ABA Therapy. If the child is covered by an additional secondary insurance policy, please provide a copy of the SBC (Summary of Benefits and Coverage)

Please share and/or attach any information citing efforts you have sought on behalf of this child to provide funding for ABA Therapy, e.g., applications for health insurance, applications for other scholarships and/or grants, negotiated discounts with therapy providers, etc.

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F.A.C.E.S. SCHOLARSHIP APPLICATION

FOR FACILITIES SEEKING FINANCIAL ASSISTANCE TO COVER THE COST MATERIALS UTILIZED FOR ABA THERAPY

NAME OF FACILITY: _____

ADDRESS FOR FACILTIY: _____

PHONE NUMBER FOR FACILITY: _____

OWNER'S NAME: _____

IS THIS ABA THERAPY CENTER NOT FOR PROFIT: YES NO

CURRENT NUMBER OF BOARD CERTIFIED BCBAs EMPLOYEED AT THIS THERAPY CENTER: _____

CURRENT NUMBER OF ABA THERAPISTS A THIS ABA THERAPY CENTER: _____

APPROXIMATE NUMBER OF CLIENTS AT THIS ABA THERAPY CENTER: _____

MONTHLY COST OF THE ABA PROGRAM AT THIS THERAPY CENTER: _____

AMOUNT THIS ABA THERAPY CENTER IS REQUESTING: _____

REASON FOR THIS REQUEST/DETAIL HOW FUNDS WILL BE USED TO DIRECTLY ENHANCE ABA THERAPY:

_____

_____

_____

Facilities **must provide any financial records evidencing their need for the financial assistance for which they are applying. Please provide two (2) years of financial statements, e.g., profit/loss statements, year-end statements, balance statements and/or tax filings.*

MISSION STATEMENT FOR THIS FACILITY: _____

_____

_____

_____

Please share and/or attach any information citing efforts you have sought on behalf of this facility to obtain funding for your request, e.g., applications for other scholarships and/or grants, additional fundraising activities, etc.: _____

_____

_____

_____

F.A.C.E.S. SCHOLARSHIP APPLICATION

FOR STUDENTS, THERAPISTS, AND/OR PARENTS SEEKING FINANCIAL ASSISTANCE FOR FURTHER EDUCATION AND/OR TRAINING IN ABA THERAPY

FULL NAME: _____

PRIMARY PHONE NUMBER: _____

SECONDANRY PHONE NUMBER: _____

EMAIL ADDRESS: _____

FOR STUDENTS:

Are you currently enrolled in an undergraduate or graduate program? YES NO

If you answered YES, what is your current GPA? _____

Are you seeking financial assistance to enroll in a course related to ABA Therapy? YES NO

Please include course name and course number: _____

Dates/semester you will be enrolled in this course: _____

Name of institution you are attending: _____

Address of institution you are attending: _____

Name of contact who processes scholarships for students: _____

Phone number of contact who processes scholarships for students: _____

Email address for contact who processes scholarships for students: _____

Cost per semester hour: _____ Cost to enroll in this course: _____

Scholarship amount requested: _____

STUDENTS MUST PROVIDE A COPY OF THEIR MOST RECENT TRANSCRIPT

**Scholarships are awarded in a manner that is most fiscally responsible for F.A.C.E.S. Scholarships for students are awarded quarterly, but students may reapply if additional financial assistance is needed. Scholarships are granted on a case by case basis by the F.A.C.E.S. Board of Directors.*

FOR THERAPISTS AND/OR PARENTS:

Name of Workshop/Training you wish to attend: _____

Date of Workshop/Training: _____

Location of Workshop/Training: _____

Cost of Workshop/Training: _____

Amount you are requesting to assist with the cost of Workshop or Training: _____

THERAPISTS/PARENTS MUST PROVIDE A COPY OF RESGISTRATION FORM FOR THE WORKSHOP/TRAINING

Are you currently employed at a facility that provides ABA Therapy? YES NO

If YES, name of Employer: _____

Contact Person/Supervisor: _____

Phone Number for Contact Person/Supervisor: _____

How long have you been employed at this facility? _____ Start date: _____

Job Title: _____

If you have any additional information or documentation that you believe would assist F.A.C.E.S. in evaluating your application, please attach to this application.

APPLICANT ACKNOWLEDGEMENT

With the submission of this application, the applicant, in their individual capacity and, if applicable, as representative as legal guardian of a child, or representative of a facility, understands:

- A complete application and the requested documents are necessary to be considered for financial assistance.
- There is no guarantee of financial assistance.
- Scholarships are awarded in a manner that is most fiscally responsible F.A.C.E.S. This decision is made on a case by case basis and determined by the F.A.C.E.S. Board of Directors.
- Scholarships may be awarded quarterly and/or annually to cover the maximum out of pocket deductible if the child's therapy is covered by insurance. Any amount awarded is based on the foundation's evaluation of the application and documentation, and the amount of funds available to the foundation at the time of the request.
- Any scholarship awarded to the applicant will be paid directly to the ABA Therapy Center, institution of higher learning, or directly to the sponsoring organization for conferences pertaining to training or continuing education which supports ABA Therapy.

In addition, if an applicant is awarded a scholarship on behalf of F.A.C.E.S., the recipient must adhere to the following guidelines and stipulations:

- If any information provided within this application changes, the applicant will supplement the application with the updated information immediately upon receiving said information, e.g., change in health insurance coverage, change in financial circumstances, change in ABA Treatment Center as noted in this application.
- If the applicant's need for requested funds ceases prior to donated funds being utilized, the applicant will notify F.A.C.E.S. immediately and arrangements will be made with the ABA Therapy Center, institution of higher learning, or sponsoring conference/organization to return all unnecessary funds.
- Scholarships will be awarded in a manner that is most fiscally responsible for F.A.C.E.S. and used solely to further the purposes of F.A.C.E.S. as expressed in this application.
- **If awarded a scholarship, the recipient agrees to allow F.A.C.E.S. to use the name of the recipient, pictures of recipient, and/or statements provided by the recipient on our F.A.C.E.S. website, promotional videos, and material that advertises and promotes the foundation.**
- **If awarded a scholarship, families of scholarship recipients will be required to volunteer (6) hours per year at (1) fundraiser.**

I, _____, acknowledge that I have completed this application to the best of my ability. I have included all requested documents and understand that I must adhere to the guidelines and stipulations sited within this application. Failure to follow these guidelines and stipulations may result in the loss of any current and/or future funding opportunities provided by F.A.C.E.S.

Printed Name of Applicant: _____ Date: _____

Signature of Applicant: _____

BUDGET

		MONTHLY AMOUNT
HOME		
	Mortgage/Rent	_____
	Second Mortgage	_____
	Taxes & Insurance	_____
	Repairs	_____
	Association Fees	_____
	Other	_____
UTILITIES		
	Electric	_____
	Gas or Oil	_____
	Water & Sewer	_____
	Phone (Landline)	_____
	Phone (Cellular)	_____
	Cable/Satellite	_____
	Internet	_____
TRANSPORTATION		
	Car Payment 1	_____
	Car Payment 2	_____
	Gas	_____
	Car Insurance	_____
	Repairs/Maintenance	_____
	Other Transportation (tolls, taxis, parking, subway, bus)	_____
INSURANCE		
	Life Insurance	_____
	Disability	_____
	Health Insurance	_____
DEBT PAYMENTS (Minimums only)		
	Credit Card 1	_____
	Credit Card 2	_____
	Credit Card 3	_____
	Student Loans	_____
	Other Loans	_____
FOOD		
	Groceries	_____
	Eating Out	_____

BUDGET cont.

FAMILY EXPENSES

Day Care	_____
Child Support	_____
Alimony	_____
School Tuition/Fees	_____

PERSONAL CARE

Gym Membership	_____
Hair Cuts	_____
Prescription Medication	_____
Toiletries/Makeup	_____
Clothing	_____

PETS

Food	_____
Care (vet, grooming, etc.)	_____

ENTERTAINMENT

Books & Magazines	_____
Movies/Concerts	_____
Music	_____
Hobbies	_____
Other	_____

OTHER

Cleaning Supplies	_____
Tithes/Donations	_____
Other	_____
	_____

TOTAL: _____

CHECKLIST

FOR INDIVIDUALS SEEKING FINANCIAL ASSISTANCE FOR THE TREATMENT OF THEIR CHILD, PLEASE BE SURE YOU HAVE COMPLETED AND INCLUDED THE FOLLOWING:

- PGS. 2, 3, & 6
- COPIES OF TAX RETURNS FOR THE LAST TWO YEARS
- COPY OF INSURANCE POLICY OR POLICIES
- COPY OF DIAGNOSIS OF AUTISM SPECTRUM DISORDER
- BUDGET (MONTHLY EXPENSES)
- FINANCIAL ASSETS STATEMENT (PART 2 OF APPLICATION)
- COPY OF SBC (SUMMARY OF BENEFITS AND COVERAGE)

FOR FACILITIES SEEKING FINANCIAL ASSISTANCE TO COVER THE COST MATERIALS UTILIZED FOR ABA THERAPY, PLEASE BE SURE YOU HAVE COMPLETED AND INCLUDED THE FOLLOWING:

- PGS. 4 & 6
- FINANCIAL RECORDS FOR THE LAST TWO YEARS EVIDENCING NEED FOR THE FINANCIAL ASSISTANCE FOR WHICH YOU ARE APPLYING, E.G., PROFIT/LOSS STATEMENTS, YEAR-END STATEMENTS, BALANCE STATEMENTS AND/OR TAX FILINGS.

FOR STUDENTS, THERAPISTS, AND/OR PARENTS SEEKING FINANCIAL ASSISTANCE FOR FURTHER EDUCATION AND/OR TRAINING IN ABA THERAPY, PLEASE BE SURE YOU HAVE COMPLETED AND INCLUDED THE FOLLOWING:

- PGS. 5 & 6
- **STUDENTS:** COPY OF MOST RECENT TRANSCRIPT
- **THERAPISTS AND/OR PARENTS:** COPY OF REGISTRATION FORM FOR WORKSHOP/TRAINING YOU ARE SEEKING FINANCIAL ASSISTANCE TO ATTEND