**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 dedicated to raising funds to directly support and promote Applied Behavior Analysis (ABA) Therapy, training, and treatment for children with Autism Spectrum Disorder (ASD).

Eligibility:

* **Individuals** applying for a scholarship must be the parent or legal guardian of a child formally diagnosed with Autism Spectrum Disorder (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. F.A.C.E.S. will only grant awards to cover the cost of ABA Therapy.
* Individuals must demonstrate a financial need for assistance. ***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 or can demonstrate that insurance coverage is not an option.*** *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.

**Documentation Required for scholarships:**

* Completed Application: Applications submitted with missing information will not be considered.
* Copy of formal ASD diagnosis
* Two most recent tax returns. If the prior year is unavailable, must include the two available PLUS proof of income for the past year. Tax returns must be complete and include any self-employment or business owner documentation.
* All applicable supporting financial documentation referenced in application
* Completed financial assets summary and budget form for any applicant with over $100,000 in annual income

**Our Process**

Completed applications are presented to the board for review on a monthly basis. The board will evaluate each case based on the demonstrated need for financial assistance. All applications must be submitted by the 20th of each month. The Board of Directors meets on the first week the following month.

Please email the completed application and all requested documents to the processing team at**: info@facesautism.org**

 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:** \_\_\_\_\_\_\_\_\_\_**AGE:**\_\_\_\_

**CHILD’S ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**CITY**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ZIP:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ETHNICITY:** \_\_ WHITE \_\_ HISPANIC, LATINO, OR SPANSIH ORGIN \_\_ BLACK OR AFRICAN AM. \_\_ASIAN \_\_AMERICAN INDIAN OR ALASKA NATIVE \_\_ MIDDLE EASTERN OR NORTH AFRICAN \_\_NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER \_\_ SOME OTHER RACE, ETNICITY, OR ORGIN

**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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOES THE ABA CENTER ACCEPT YOUR INSURANCE AS AN IN-NETWORK PROVIDER? \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_

**COST OF ABA THERAPY PROGRAM PER MONTH** *IF COVERED UNDER INSURANCE, PLEASE LIST ESTIMATED MONTHLY COST OF COPAYS OR ANNUAL DEDUCTIBLE+OUT OF POCKET MAXIMUM)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCHOLARSHIP AMOUNT REQUESTED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHAT TIME FRAME WILL THIS AMOUNT COVER?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.*

**INSURANCE INFORMATION** (please attach copies of benefit summaries and id cards for all policies except Medicaid)

Please check all insurance coverages: Medicaid \_\_\_\_\_\_ Employer Insurance \_\_\_\_\_ Child-only policy \_\_\_\_\_

If employer policy, does it cover ABA? \_\_\_\_\_\_\_\_ Do you carry a secondary policy specifically for ABA? \_\_\_\_\_\_\_

If you have NO insurance check here: \_\_\_\_\_ If you have insurance, but none that covers ABA, check here\_\_\_\_\_

Cost to cover your child per month: Employer Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child Only Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Specifically regarding the policy that covers ABA, if applicable:*

Subscribers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S PRIMARY PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S SECONDARY PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S CURRENT ANNUAL INCOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S PRIMARY PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S SECONDARY PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S EMPLOYEER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S CURRENT ANNUAL INCOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 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 or to an insurance company to pay for premiums for the applicant. No monies will be paid to an applicant.

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.
* Scholarship funds are available only for the calendar year which they are approved for. Unused funds will not roll over to future years.
* **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.**
* **Complete a six-month survey concerning progress noted with your child since beginning A.B.A. therapy. This document will be sent to you at a later date.**

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**

|  |  |
| --- | --- |
| **HOME** |  **MONTHLY AMOUNT** |
|   | 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:***

* ALL PAGES OF THIS APPLICATION
* COPIES OF COMPLETE TAX RETURNS WITH ALL SCHEDULES AND ADDENDUMS FOR THE LAST TWO YEARS
* IF TAX RETURNS ARE NOT AVAILABLE FOR THE MOST RECENT YEAR, YOU MUST ALSO INCLUDE COPIES OF W2S, 1099S, K1 AND ALL OTHER INCOME RELATED DOCUMENTATION FOR THE MOST RECENT YEAR
* 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)
* COMPLETE SIX MONTHS POST THERAPY IMPACT SURVEY (A BOARD MEMBER WILL SEND THIS SIX MONTHS AFTER ABA THERAPY BEGINS)