AHFF Request for Assistance

FINANCIAL ASSISTANCE APPLICATION FORM

PLEASE NOTE THE FOLLOWING APPLICATION GUIDELINES

a. Applications must be made on behalf of a specific child aged birth through 21 years at the time of the application who is living in the state of Kansas, in the United States.
b. Financial Assistance or Scholarship may be rewarded for children receiving therapies and/or services through a proven company.
c. Scholarship requests could be used for adaptive equipment, assisted technology, hospital bills.
d. Funding is available only for families of a child affected by autism spectrum disorder and must be for services and therapies deemed to benefit that child.
e. Please complete a separate application for each child.
f. All financial information pertains to the parent(s)/guardian(s) of the child.
g. The form must be signed by the parent(s) or legal guardian(s) of the child you are applying on behalf of.
h. Supporting documentation must be provided at the time of submission, even if you have applied for funding before.

1. Applicant Details (information on the child services are requested for)

Child's Name: ____

Child's Address: ____

Child's Age:__________ Date of Birth: ______________________________

Child's Diagnosis(es):______________________________________

Age at Diagnosis:____

Diagnosed By: ____

Current School:____

2. Family Information (information on parent(s)/guardian(s) of the above child)

Mother's Name: ____

Mother's Address: ____

Mother's Phone:____________________ Mother's Email: ______________________

Father's Name: ____

Father's Address: ____

Father's Phone:____________________ Father's Email:_______________________

Marital Status:□Married/Cohabiting □Single Parent □Widowed □Divorced/Separated

How did you learn about Autism Hope for Families, INC:

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____

____

3. Assistance Requested (if a section does not pertain to your child write NA)

A. Assistive Technology Requested:

   ____

Reason for Assistive Technology: ____

____

____

B. Hospital or Therapy Bill assistance:

   ____

Reason for the hospitalization or therapy:______________________________________

C. Program Requested:

   ____

To Attend (days/week):____

D. Therapy/Services
   Needed:____

Frequency of Therapies:____

***** Request to attend or are currently attending a facility for therapies or school, please complete the information below.**

Facility Name:____

Facility Address: ____

Facility Phone: ____

Contact Name: ____

Attending Since:____

Facility Tuition:____

Therapy/Services Received:____

Frequency of Therapies:____

4. Financial Information

4.1 Parent/Guardian Financial Status (circle week/month/year)

Total GROSS Earnings of Parents/Guardians: $__________ Per Week/Month/Year

Other Income:
- Benefits: $__________ Per Week/Month/Year
- Child Support/Alimony: $__________ Per Week/Month/Year
- Pension: $ __________ Per Week/Month/Year
- Disability: $ __________ Per Week/Month/Year
- Maintenance: $ __________ Per Week/Month/Year
- SSI/SSD: $ __________ Per Week/Month/Year
- Other: $ __________ Per Week/Month/Year

4.2 Parent/Guardian Employer Information

Father/Guardian 1 Job Title: ____

Employer:____

Address:____

City, State, Zip:____

Phone Number:____

Mother/Guardian 2 Job Title:____

Employer:____

Address:____

City, State, Zip:____

Phone Number:____

4.3 Parent/Guardian Financial Commitments

EXPENSES FOR	AMOUNT (monthly)	PAID TO	OTHER NOTES

Mortgage/Rent	$		
Utilities	$		
Auto Payments	$		
Auto Insurance	$		
Medical (out of pocket)	$		
Other	$		
Other	$		

Explain any special circumstances pertaining to your financial situation, either temporary or long-term (i.e. medical bills, job loss, layoffs, etc.): ____________________

____
____
____
____
____
____

Other Dependants: Birth Date:____________ Special Needs: ____________________
Birth Date:____________ Special Needs: ____________________
Birth Date:____________ Special Needs: ____________________

5. Other Information

What benefits would this assistance bring to your child and/or your family? Please include any comments or other information you wish to share.:

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I hereby confirm that I have provided within this form all requested information to the best of my knowledge. I understand that failure to disclose full details or falsifying information could invalidate my application and allow for further legal action by **Autism Hope for Families, INC.**

Name (printed):____

Relationship to Child: ____

Signature:_____________________________________ Date:_______________

Please include the following mandatory documents:

□ A copy or digital picture of the front and back of Page One of IRS Form 1040, along with copies of all W-2's and any 1099 Form(s).

□ A copy of the Physician's Letter(s) **OR** letter from their school **OR current** copy of IEP specifying child's diagnosis(es), along with details of any therapies/services recommended/prescribed by the Physician(s) or school. ***For example if you are seeking assistive technology, please have the speech teacher or speech provider include a recommendation for the device.***

Please return your completed application, along with the necessary attachments, to:
Autism Hope for Families – 1524 S. Plummer Ave, Chanute, KS 66720
Once your application has been received and reviewed, you will be contacted.

*** **Austism Hope for Familes, INC** does not discriminate against individuals on the basis of race, color, sex, sexual orientation, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin in the administration of its funding.

Autism Hope for Families, INC USE ONLY
Date Received: _______________________
Via:__________________ Review:_____________ Contact:_________________
Interview Info: _____________________________________
Other: ____
Notes: