Therapy Assistance Grant Application 2019

Thank you for your interest in our Therapy Assistance Grant program for 2019. This program is a key part of fulfilling our mission to increase access to effective autism therapies in the Chicagoland area. As this is the first year of this program, funds may be limited. But our board of directors will do all they can to award as many grants as possible.

<u>Important Information Regarding the Grant & Application:</u>

- Applicants must have a current autism diagnosis and have a permanent address in Illinois.
- Applicants may apply for up to $8,000 or the amount of their max out-of-pocket limits for their insurance plan, whichever is lower.
- If you are applying for multiple services from multiple providers, please fill out page 6 for each provider for whom you would like for financial assistance. If you're requesting all services from the same provider, you only need to fill out page 6 once, but check all services you will be requesting.
- If you are selected for a grant, payments will be made directly to service providers for any combination of approved therapies (see list of approved therapies on page 6 of the application). Service providers will run insurance benefits first, and then bill Chicago Autism Network the remaining amount due, up to the agreed upon amount. Please note that grant money cannot be used to cover unapproved fees, such as late/cancelation fees.

To be considered for assistance, please make sure you meet the following requirements:

- ☐ Submit complete application including the following:
  - Completed application;
  - A one-page personal statement detailing your circumstances and specific plans you have for using grant funds;
  - A signed letter of recommendation from a service provider, case worker, or other individual familiar with your situation; and
  - A copy of a current pay stub (dated within 30 days) or 2017 tax returns.

  Please submit all documents. Incomplete applications will not be considered.
- ☐ Submit application either by
  - emailing a PDF copy to info@chicagoautismnetwork.org by October 27, 2018, or
  - mailing a hard copy to

    Chicago Autism Network
    PO Box 804914
    Chicago, IL, 60608.

    Mailed applications must be postmarked by October 27, 2018.

Please note, individuals of all ages are welcome to apply. Each individual must have a separate application (siblings cannot share an application).

Grant recipients will be announced by November 30, 2018.

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Applicant Information

Name:			Date of Birth / /
Street Address:			Date of Autism Diagnosis (Month/Year) /
City	State	Zip	Phone Number
Email Address:	Gender: M F		Ethnicity
Current School	Grade		Primary Language

Guardian #1 (if applicant is 18 yrs or younger)

Name:			Cell Phone Number
Street Address: (If different from applicant)			Work Number
City	State	Zip	Occupation
Primary Language	Email Address		
Number of people living in household	Number of children under 18 living in household	Ages of other individuals in household with ASD diagnosis (if any):	

Guardian #2

Name:			Cell Phone Number
Street Address: (If different from applicant)			Work Number
City	State	Zip	Occupation
Primary Language	Email Address		

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History

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the grant review process. I give Chicago Autism Network permission to verify treatment information by contacting the health care providers below. I understand that I may revoke this authorization in writing at any time.

Applicant Name _____ Date of Birth _____

Guardian Name_____ Relation to Applicant _____

Signature _____ Date _____

Current Diagnosis		Date of Diagnosis (Month/Year)
Name of Diagnosing Physician/Psychologist	Name of Institution/Practice	
Street Address	Phone	
City	State	Zip
Other Medical Diagnoses		

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Financial Information

(please attach current pay stub dated within 30 days or a copy of last year's tax returns to verify income)

Income Source #1 Current Employer	Title	Annual Income $
Income Source #2 Current Employer	Title	Annual Income $
Other Income Source		Amount $
Total Annual Income		Amount $

Are your current recipients of the following assistance programs? ☐ WIC ☐ SNAP	Grant Amount Requesting (not to exceed $8,000 or insurance max out of pocket) $

If Chicago Autism Network is unable to fund your full request, would you be interested in receiving partial assistance?

☐ Yes ☐ No

Are you receiving any other financial assistance or grants that are helping you cover therapy costs?

☐ Yes ☐ No

If yes, please explain below:

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Insurance Information

Is applicant currently insured? Y/N	If approved for a grant, will applicant apply for insurance? Y/N	
Primary Insurance Company	Circle One HMO / PPO	Circle One Individual Plan / Family Plan
Insurance Phone Number	ID #	Group #
Deductible Amount $	Circle One Fully Insured / Self Insured **	Max. out of pocket (write family max amount if a family plan) $
Secondary Insurance Company	Circle One HMO / PPO	Circle One Individual Plan / Family
Insurance Phone Number	ID #	Group #
Deductible Amount $	Circle One Fully Insured / Self Insured **	Max. out of pocket: circle either family or individual $

**Please double check with your employer or insurance company to see if you are fully-insured or self insured. Fully insured policies follow the IL mandate to cover autism treatment. Self-insured policies don't necessarily follow the mandate, so it's important to know the difference.

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Grant Request

(fill out this page for each service provider you plan to use. Make additional copies of this page if necessary)

Please check the support(s) below for which you would like financial assistance (Check all that apply).

- ☐ Speech Therapy
- ☐ ABA Therapy
- ☐ Dialectical Behavior Therapy
- ☐ Social Skills Groups
- ☐ Occupational Therapy
- ☐ Pharmacotherapy
- ☐ Other Psychotherapy
- ☐ Therapeutic Day School
- ☐ Physical Therapy
- ☐ Cognitive Behavioral Therapy
- ☐ Educational/Developmental Therapy

Provider Name:			Provider Phone Number
Street Address:			Provider email
City	State	Zip	Is provider in-network with your insurance? ** Y/N N/A
Are you currently receiving services from this provider? Y/N			Is requested therapy covered by your insurance? Y/N N/A

**Please note that if you have insurance, we will only cover services that are in-network with your carrier. Exceptions may be made for situations where a suitable in-network provider cannot be found, but must be approved by Chicago Autism Network.

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Authorization to Use and Disclose Protected Health Information (PHI)

(*Please complete this form for each service provider for whom you would like to receive therapy assistance. Make additional copies if necessary.)

When completed and signed by you, this form authorizes the service provider to release protected health information from your records to Chicago Autism Network.

Patient Name: _____ Date of Birth _____

I, parent or legal guardian for the above-named child, authorize the following person(s) or institution to provide information to Chicago Autism Network, including, but not limited to the following:

- Attendance Records;
- Progress Reports;
- Session Notes; and
- Evaluations.

Service Provider Name: _____

Address: _____

Phone Number: _____

This release of information is valid from October 1, 2018 to December 31, 2019.

I understand that I may revoke this Authorization at any time by sending a letter to the above service provider. However, I understand that I may not revoke Authorization for any actions taken before my receipt of written notice to revoke this Authorization. I also understand that this Authorization must be in place for me to be eligible for Therapy Assistance Grant money, and termination of this Authorization will result in termination of my grant.

I have had the opportunity to read this Authorization and agree with the statements made in this form. I understand that, by signing this form, I am confirming my authorization of use and/or disclosures of PHI described in this form.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Printed name of Parent/Guardian: _____

Relationship to patient: _____

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I _____ certify that the information on this application is
(Name of individual who prepared the application)

true and correct to the best of my knowledge. I understand that falsifying any information on this application, including failure to disclose income sources, will result in the immediate termination of this grant.

Signature _____ Date _____