KNOWAutism
A Foundation for Children with Autism

# 2019 Tuition & Therapy Assistance Program

The KNOWAutism Tuition & Therapy Assistance Program offers scholarships to financially disadvantaged children with autism between the age of 12 months and 18 years of age to assist with the cost of attending a special-needs school or therapeutic program.

Available award amounts range from $1,000 to $5,000. The number of available awards at each grant level is dependent on available funding.

The Program Committee evaluates applications based a number of different criteria. For approved applications, the Committee selects the grant amount to be awarded based upon available funding and the demonstrated financial need of the eligible applicants. Families applying for the first time are given preferential consideration, but families may apply one time per calendar year, for up to a total of three (3) awards per eligible child.

**Eligibility Requirements:**

1. Applicants must demonstrate a need for financial assistance and provide relevant information for the committee to review.
2. Applicants must be the parent or legal guardian of the child, and the child must be between the ages of 12 months and 18 years of age.
3. The child must have a formal diagnosis of Autism Spectrum Disorder (ASD) or closely-related disorder and be attending one of the following:
    a. A special-needs school and/or special education program
    b. Speech therapy, occupational therapy, and/or physical therapy
    c. Applied Behavior Analysis or other behavioral therapy
    d. Social skills program
4. Applicants must submit a complete application. If the family is seeking assistance for more than one child, a separate application must be submitted for each child.
5. Applicants must provide documentation of an ASD diagnosis. This may be in the form of a diagnostic assessment or report, letter from treating physician, copy of IEP, SSI or Medicaid determination letter, documentation from the school district, or other similar documents.

**Review Process:**

The Program Committee reviews applications on a quarterly basis and selects a limited number of applicants to receive financial support scholarships. A member of the committee may contact you to request additional information or documentation if needed.

The time it takes for an application to be reviewed varies. However, if you have not been contacted within 2 weeks of submitting your application, you may request an update or confirmation that your application has been received.

All applicants will receive notice of the decision made on their application. Typically, a committee member will contact you at the e-mail or mailing address provided on your application to notify you of the committee's decision.

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**Award Acceptance Requirements:**

If you are selected to receive assistance, you will receive an award letter and an acceptance agreement, which must be read, signed, and returned.

You will also be asked to provide a photo of the scholarship recipient and grant KNOWAutism Foundation permission to use your child's photographic likeness in its publications, social media, website, fundraising materials, and/or other media. Recipients must also provide a thank you note or letter explaining how the award will impact your family.

All scholarship checks will be issued in the name of the provider, facility, or program for your child's therapeutic services, as indicated on your application and agreement.

**Confidentiality of Personal Information:**

KNOWAutism Foundation values your trust and understands the importance of protecting your privacy. All applications and documentation provided will be maintained in confidence, in accordance with the Foundation's privacy practices.

Any Personal Health Information you provide will be considered confidential and will only be used or discussed as appropriately required in connection with the review of your application, provision of requested services, and the Foundation's work.

Some information provided in your application or award agreement may be anonymized and/or aggregated with other data for use in reports or publications for purposes such as reporting for donors/grants, outreach and awareness initiatives, or fundraising efforts in support of our mission. Except as outlined above, we will not use or disclose your personal information unless we receive your authorization and consent.

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## 2019 TUITION & THERAPY ASSISTANCE APPLICATION

**Full Name (Parent/Guardian):** _____

Street Address _____ Apt/Suite/Unit _____

City _____ State _____ Zip Code _____

Phone _____ Is it okay to leave a Voicemail? ◯ Yes ◯ No

E-mail _____

How did you hear about KNOWAutism? _____

*Date of Application* _____

## STUDENT'S INFORMATION

**Full Name (Student)** _____

Date of Birth _____ Social Security (last 4 digits) _____

*Please briefly describe the student and their experiences so far ASD and therapeutic services. Include any information that you believe would be helpful for our consideration.*

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## FACILITY / PROVIDER / PROGRAM INFORMATION

**Facility/Provider Name:** _____

Street Address _____ Apt/Suite/Unit _____

City _____ State _____ Zipcode _____

Contact Person _____ Title/Role _____

Phone _____ E-mail _____

**Program Name / Grade Level** _____

Therapeutic Approach (i.e. ABA, PRT, DIR, OT, etc.) _____

How often does your child receive these services? _____

**Cost of Tuition/Fees** (specify if per session, week, month, or year) _____

## FINANCIAL INFORMATION

**Gross Annual Income** *(total for household)* $_____

Household Size _____ How many are dependents? _____

**Please describe your financial situation and why you are seeking assistance.** Please include relevant information explaining why the cost of these services creates financial strain or hardship.

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## FINANCIAL INFORMATION (Continued)

What **health insurance** does your child have? _____

**Annual Deductible** (Individual / Family) $_____

*Amount Paid* $_____ *as of (date)* _____

**Out-of-Pocket Maximum** (Individual / Family) $_____

*Amount Paid* $_____ *as of (date)* _____

Does your child's health insurance plan cover any portion of the services for which you are seeking assistance? ◯ Yes ◯ No

If your child's plan does not provide coverage for these services, have you been provided with an explanation regarding why coverage has been denied?

_____

_____

What is your **out-of-pocket responsibility** (i.e. co-pay, co-insurance, or self-pay rate) for the therapeutic program or services your child is receiving (specify per session, week, month, and/or year)?

_____

_____

_____

**Please list all additional sources of financial support your family has received or may receive this year, including any pending applications for assistance** (i.e. scholarships, grants, Medicaid, SSI, food assistance, child support, etc.)

_____

_____

_____

_____

Have you previously been awarded a grant from KNOWAutism? ◯ Yes ◯ No

*If yes, list year(s) and award amount(s)* _____

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## 2019 TUITION & THERAPY ASSISTANCE APPLICATION

Is there anything else you would like for us to know?

_____

_____

_____

_____

## SIGNATURE

*By signing this form, you certify that all answers provided are true and complete to the best of your knowledge. You also certify you have read and understand the eligibility requirements, review process, acceptance requirements, and statement on confidentiality provided with this application*

*By submitting this application and providing your personal information to us, you accept and agree to be contacted by a representative of the Foundation and to have your personal information used by the Foundation for the purposes of reviewing your application and/or providing requested services, in accordance with our privacy practices.*

**Signature** _____ **Date** _____

Applicant Name (Print) _____

## SUBMISSION

Submit completed applications to info@know-autism.org using a typed digital copy or *clear* scanned copy, or mail printed application to the address below:

KNOWAutism Foundation
Attn: Tuition & Therapy Assistance Program
6430 Richmond Ave, Suite 410
Houston, TX 77057