

FACES - Foundation for Autism Care, Education and Services

Application for Scholarship or Grant Funding

Please check ONE of the following:

____ Individual

I have a child/children with Autism Spectrum Disorder.

I am financially unable to afford an ABA program.

I want to enroll my child/children in an ABA program

I can demonstrate my commitment to an ABA program.

____ Organization

Our organization supports the care, treatment, services and education of children with Autism Spectrum Disorders.

Our organization supports ABA as the appropriate primary approach to therapy.

Our organization will use the funds to promote ABA and the care, education and services of children with ASD.

____ Center/clinic/school

Our center/clinic/school uses ABA as its primary, main approach to therapy for children with Autism Spectrum Disorders.

Our center/clinic/school will use the funds to continue our care, treatment, education and services for children with ASD.

Contact Name _____ Phone _____

Title _____

Address _____

It is the policy of the Foundation for Autism Care, Education, and Services to give equal opportunity to all persons and organizations on the basis of their qualifications and be treated equally in these and all other respects without regard to race, color, religion, sex, marital status, age, handicap or national origin.

Foundation for Autism Care Education and Services

EIN#20-4767823

Individuals applying fill out the following:

Name of child/children _____

Age(s) _____ Diagnosis _____

Current Placement _____

Center/Clinic/School I wish to attend: _____

Cost of program: _____ Is there a waiting list for this program? Y N

Total Amount Requested: _____

Time Frame for Amount requested to be used: _____

Reason for choosing this program: _____

Mother's Employer _____ Annual Income _____

Address _____ Please provide last 2 yrs tax returns.

Phone _____

Father's Employer _____ Annual Income _____

Address _____ Please provide last 2 yrs tax returns.

Phone _____

Amount (if any) you are able to contribute _____

Health Insurance Provider _____

Will your Health Insurance Provider cover Behavioral Treatment? Y N

Please put your initials next to each of the following indicating your understanding:

___ I understand that I will not receive the funds directly.

___ I understand that my child/children must be in attendance 85% of therapy days.

___ I understand that I must attend 85% of consultation hours.

___ I understand that I must attend 85% of training hours.

___ I understand that all of the above are conditions for retaining this scholarship.

___ I understand that there is no guarantee of renewal of scholarship(s).

___ I understand that the center/clinic/school will provide a report of my child's/children's attendance, my attendance to consultation and training, and a progress report to the board of this foundation.

___ I waive all confidentiality pertaining to the information required for the school to send their report to the scholarship committee.

___ I understand that if I receive insurance reimbursement for my child's treatment, I will receive scholarship funds ONLY for covering the deductible and upfront costs.

___ I agree to inform FACES of any insurance reimbursements I receive.

___ I agree to allow the center/clinic providing services to inform FACES of any insurance coverage I pursue/receive.

Signature of Mother Date

Signature of Father Date

Please give a brief description of your family's demonstration of commitment to ABA and treatment for your child(ren) and why FACES should consider you for award of a scholarship.

Organizations applying fill out the following:

Name of Organization_____

Contact Name_____

Address_____ Phone_____

Web Site Address_____

Mission of your organization:

Does your organization support or promote Applied Behavior Analysis? Yes No

Is your organization not for profit? Yes No

Amount of funding for which you are applying:_____

Reason:_____

Does this funding go for: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Promotion of ABA | <input type="checkbox"/> Services for children with ASD |
| <input type="checkbox"/> Treatment for children with ASD | <input type="checkbox"/> Education for children with ASD |
| <input type="checkbox"/> Research of ASD | <input type="checkbox"/> Other |

Explain how this funding furthers the purpose of this foundation and your organization:

Signature of Applicant

Date

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Centers/Clinics/Schools applying fill out the following:

Name of Center/Clinic/School _____
Contact Name _____
Title _____
Address _____ Phone _____
Web Site Address _____
Mission of your center/clinic/school _____

Does your center/clinic/school provide Applied Behavior Analysis as its **main** therapy? Yes No
Is your center/clinic/school not for profit? Yes No
Number of clients enrolled in your program (total/all locations) _____
Cost of your program: Full time _____ Part time _____ Other program _____
Amount of funding for which you are applying: _____
Reason: _____

Does this funding go for: (check all that apply)
 Promotion of ABA Services for children with ASD
 Treatment for children with ASD Education for children with ASD
 Research of ASD Other

Explain how this funding furthers the purpose of this foundation and your center/clinic/school:

Signature of Applicant _____ Date _____

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**Scholarship and Grant Funding Guidelines/Rules
for
Private Individuals, Organizations and Centers/Clinics/Schools**

1. There is no guarantee of award.
2. The number and dollar amount of awards are based on amount of funds available to the foundation and reason for request for funding.
3. Applications must be complete.
4. Parents, private individuals must demonstrate their personal commitment to ABA therapy as the approach for the treatment, care, and education of the child/children.
5. Organizations, clinics, centers or schools must demonstrate it promotes ABA as the main approach to therapy for children with Autism Spectrum Disorders.
6. Individuals must pursue insurance reimbursement or provide proof that insurance will not reimburse for treatment in the form of a denial letter from the insurance company.
7. The foundation does not discriminate in regards to race, color, religion, sex, marital status, age, handicap or national origin.

If your organization, center, clinic or school is awarded funding, you must adhere to the following rules:

1. If your school is the recipient of an individual's scholarship, you must provide quarterly reports on attendance of the child, dollars contributed by the parent (if any), attendance of the parent to consultation and training opportunities, child's progress, and any increases in fees/costs to parents. Additionally, your school/clinic/center must provide information regarding insurance coverage of a client to FACES if applicable.
2. If your school is the recipient of a grant, you must provide evidence of expenditure for the intended purpose of the grant. Pictures, receipts, and narratives of how the dollars were put to use and the outcome, efficacy of the expenditure within 3 months of receipt of the grant.
Failure to provide the report will prevent any further funding opportunities.
3. Any grant your organization, center, clinic, or school receives must further the purposes of the foundation.

I, _____, representing _____ (organization, center, school, clinic) understand the above conditions and guidelines. My signature below indicates my understanding and receipt of these rules. I promise to adhere to the conditions and guidelines as stated and realize if I do not adhere to them, my organization, center, clinic or school will lose future opportunities for funding.

Signature

Date

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