Hope For Three

Autism advocates. Providing help. Creating hope.

Hope For Three
Family Assistance

Family Assistance Reapplication

Only eligible for those have submitted complete applications within the last 12 months and are requesting funding for same service/provider

Applicant Information

Amount Requested: _____ Date: _____

Applicant Name: _____
Last *First* *DOB*

Guardian Name: _____
Last *First* *Relationship*

Current Address: _____
Street *City* *Zip*

Phone Number: _____ Email: _____

Provider: _____ Service: _____

Summary of Request for Reapplication:

Additional Comments:

_____
Guardian Signature *Date*

OFFICE USE ONLY

Date Received: _____ Past Application Pulled: ☐ Yes ☐ No

Reapplication Eligible: ☐ Yes ☐ No Additional Docs Needed: _____

_____
Family Assistance Coordinator Signature *Date*