Blessed Be Hope For Three, Inc.
Family Assistance Program

Blessed Be "Hope For Three", Inc. is a 501(c)3 nonprofit organization whose mission is to reach one child, one family, one community by creating awareness and providing support to families living with autism. Through our Family Assistance Program, we offer financial aid to families in the Fort Bend area for assessment, treatments, therapies, services, and supports that may not otherwise be covered by insurance.

Applications are accepted by Hope For Three throughout the year.

Funding is only paid to an approved service provider, treatment facility, assessor, or supplier. Hope For Three's Family Assistance Committee will have final authority on each financial award.

The applicant receiving assistance agrees to repay monies received if any services paid by Hope For Three Family Assistance Program are reimbursed by another funding source, such as an insurance company.

To be considered for financial assistance from Hope For Three, your application must include the following:

- A completed, signed, and dated Family Assistance application. Incomplete applications will not be considered or returned.
- Documentation of diagnosis of Autism Spectrum Disorder or Social Communication Disorder.
- A copy of your previous year's tax return.
- A financial quote from a service provider or facility on letterhead.

Family Assistance applications may be mailed or hand-delivered to:

HOPE FOR THREE
12808 W. Airport Blvd., Ste. 375
Sugar Land, TX 77478

Please contact Samantha Katchy via email at Samantha@hopeforthree.org or call 281-245-0640 if you have further questions.

Please sign and date below to acknowledge that you have read and understand the application process set forth by Hope For Three.

Parent/Caregiver Signature Date

Family Assistance Application

Families with multiples should list one child as "Applicant" and additional applicants under "Dependent/Sibling Information" below.

Today's Date:	Funding Year:	Total Amount Requested:	
How did you hear about our Family Assistance Program?			
Applicant's Name:		Applicant's DOB:	Gender (please circle): Female Male
Home Address:			
City:	State:	Zip Code:	
Guardian #1 Name:	Marital Status:	Relationship to Applicant:	
Home Phone:	Cell Phone:	Work Phone:	
Email address(es):			
Guardian #2 Name:	Marital Status:	Relationship to Applicant:	
Home Phone:	Cell Phone:	Work Phone:	
Email address(es):			

Dependent/Sibling Information

Name:	Age:	Relationship to Applicant:	Autism Spectrum Disorder Diagnosis (please circle one): Yes No
Name:	Age:	Relationship to Applicant:	Autism Spectrum Disorder Diagnosis (please circle one): Yes No
Name:	Age:	Relationship to Applicant:	Autism Spectrum Disorder Diagnosis (please circle one): Yes No
Name:	Age:	Relationship to Applicant:	Autism Spectrum Disorder Diagnosis (please circle one): Yes No

TOTAL NUMBER OF HOUSEHOLD MEMBERS: _____

History

This form authorizes the use and/or release of the protected health information as noted below for the Hope For Three review process. I give Hope For Three permission to verify treatment information by contacting the service provider(s) directly.

Signature/Date

Please note that History and Funding Source pages **must** be completed for each applicant. Additionally, proof of diagnosis **must** be provided.

Applicant Name:			Date of Birth:
Current Diagnosis:			Date of Diagnosis:
Diagnosed by (Name of Physician):			
Name of Institution where Applicant was Diagnosed:			Phone Number:
Street Address:	City:	State:	Zip Code:

Treatment

Please note that supporting documentation **must** be attached from each service provider.

Type of Treatment	**Treatment History (please circle one)**	**Frequency** (example: 2 hrs. per week)	**Service Provider**
Speech Therapy	Current Past Not Applicable		
Occupational Therapy	Current Past Not Applicable		
Physical Therapy	Current Past Not Applicable		
Applied Behavior Analysis	Current Past Not Applicable		
Special Diets	Current Past Not Applicable		
Biomedical Testing	Current Past Not Applicable		
Biomedical Intervention	Current Past Not Applicable		
Social Skills Groups	Current Past Not Applicable		
Auditory Integration Therapy	Current Past Not Applicable		
Respite	Current Past Not Applicable		
Other (please explain)	Current Past Not Applicable		

Funding Sources
(Including grants or scholarship awards)

Complete all funding sources that apply and complete the requested information for **each** applicant.

Private/Health Insurance		
Insurance Company:	Contact Person:	Phone Number:
Treatments Covered:		

Regional Center		
Regional Center:	Contact Person:	Phone Number:
Services Provided:		

School District		
School District:	Contact Person:	Phone Number:
Services Provided:		

County		
County:	Contact Person:	Phone Number:
Services Provided:		

Other		
Describe:	Contact Person:	Phone Number:
Services Provided:		

Description of Request for Assistance

Please describe the specific details for your request for assistance. You may use the space below or attach a separate sheet. To assist in our review, you may also provide letters of recommendation from service providers, case workers, or other individuals familiar with your family situation. Letters of recommendation are optional and should be no more than one page in length. If you attach additional sheets, please place a check mark here. ___

Funding Information

Please note that applicants who do not have the financial means to meet the gap between cost of service and Hope For Three's financial assistance award will not be considered.

1. Total amount of funding request: _____

2. What other sources will you apply to for assistance?

_____

_____

_____

_____

3. Please attach quote(s) from provider(s) on letterhead for projected cost of service(s).

Please list the name(s) of service provider(s) or treatment facility where payments will be submitted.

Service Provider:		
Contact Name:	Email:	
Address:		
City:	State:	Zip Code:
Phone Number:	Website:	
Service Provider:		
Contact Name:	Email:	
Address:		
City:	State:	Zip Code:
Phone Number:	Website:	

Income and Expenses

Grantors who provide funding to Hope For Three often request information regarding our applicant's income and expenses to determine a family's financial status. This information is confidential and will only be used by the Family Assistance Coordinator to advocate for your child(ren)'s application based on the information provided for consideration. In addition to your income tax statement or other proof of income, please provide the following information:

MONTHLY INCOME

Income for Parent #1 Source: ____ Employment ____ Retirement Benefits ____ Other	Gross $	Net $
Income for Parent #2 Source: ____ Employment ____ Retirement Benefits ____ Other	Gross $	Net $
All Other Household Income Source: ____ Employment ____ Retirement Benefits ____ Other	Gross $	Net $
TOTAL		

ASSETS

Specify Sources (Stocks, Bonds, Savings, Investments, Interest Bearing Accounts, etc.) Value $_____

Do you: ____ own your own home ____ rent ____ other?

HOUSEHOLD EXPENSES

Enter your household average expenses for the following items. Do not include expenses that are deducted from paychecks.

House/Rent Payments $_____
Payments/Other Real Property $_____
Automobile Payments $_____
Gas and Auto Maintenance $_____
Cell Phone(s) and/or Landline $_____
Groceries/Household Supplies $_____
Utilities $_____
Medical care (not covered by insurance) $_____
Dental care (not covered by insurance) $_____
Auto Insurance $_____
Life Insurance $_____
Medical and Dental Insurance $_____
Child Care $_____
Child Support Payments $_____
Credit Cards $_____
Other Charitable Donations $_____
Student Loans $_____
Recreation/Entertainment $_____
Clothing $_____
Other $_____
Other $_____
Other $_____
TOTAL EXPENSES $_____

Privacy and Terms of Use Policy

Blessed Be "Hope For Three", Inc. respects your rights of privacy. Your privacy is very important to us. The information received by Hope For Three will be used solely to determine awarding financial assistance. We will not sell or share your personal information with any person, group, or organization other than a representative of our agency.

Please be advised that your story, name, and photos may be used for marketing purposes and by signing below, you authorize Hope For Three to do so.

Although the agency has taken reasonable precautions to ensure viruses are not present in any electronic correspondence, the company cannot accept responsibility for any loss or damage arising from the use of email and any attachments. Although we make every effort to be secure, Hope For Three cannot guarantee the security of personal information or other information in any form. Please do not provide or allow others to provide personal information about anyone unless you, on your own behalf or on behalf of anyone whose information you provide, are authorized to do so.

Personal information should be truthful and accurate. Any attempt to provide false information will result in the withdrawal of your application and it will be removed from consideration for any assistance from Hope For Three in the future. If assistance is awarded based on false information, it may result in legal action against the person nominating the child(ren). Submission of all personal information constitutes an agreement with the Hope For Three Privacy and Terms of Use Policy.

Applicant agrees to indemnify, defend, and hold harmless Hope For Three from and against any and all losses, damage, liability, and cost of every nature incurred by them in connection with any claim, damage, or loss related to, or arising out of, any assistance or services provided, or any alleged breach by you of these terms. Applicant agrees to cooperate fully in the sense of the foregoing. From time to time, Hope For Three may amend the Privacy and Terms of Use Policy. In doing so, all amendments shall be effective immediately. Please check website for updates.

To the full extent allowed by law, you agree that Hope For Three will not be liable to you or anyone else for any special, consequential, incidental or punitive damages, damages for lost profits, loss of privacy or security, loss of reputation, failure to meet any duty (including, but not limited to the duty of good faith or lack of negligence or of workmanlike effort), or for any other similar damages whatsoever that arise out of, or related to, any aspect of the application and personal information disclosed.

Hope For Three does not discriminate against race, gender, or religion.

With your signature below, you agree to the Privacy and Terms Use Policy and give Blessed Be Hope For Three, Inc. permission to contact all related service providers as listed on this application.

_____ _____

Signature of Parent or Legal Guardian of Applicant Date

Family Assistance Check List

Please use this check list to ensure all information is included and completed with your application.

____ Application completed, signed, and dated

____ Proof of diagnosis (documentation from physician, school, or provider)

____ Description of request for assistance

____ Proof of Fort Bend County residence

____ Supporting documentation (i.e. quote(s) from service provider(s) on letterhead)

____ Letters of recommendation (optional)

____ Copy of previous year's tax return

____ Signed Privacy and Terms of Use Policy

Notes:

_____

_____

_____

_____

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