



Need Assistance? Please read the information below to find out how to apply for Quick Assist.

Q: How much money can I request?

A: The maximum amount we award per family is a one-time grant of \$500.

Q: How do I apply for assistance from Hope For Three?

A: You must complete and submit an application for assistance (mail, email, or drop-off), along with supporting documents.

Q: Are grant funds paid directly to families?

A: No. Grant payments will be paid directly to approved treatment providers, assessors, vendors or suppliers.

Q: I've sent my application in. How long until I know if my application has been approved?

A: Once we have received all components of the application (complete application form, doctor's letter, and tax return, if applicable), your application will be reviewed within two weeks. The number of grants awarded per month would be based on funding available. Awards will not exceed \$500 per family.

Q: I have health insurance. Can I still apply for assistance?

A: Yes.

Q: I'm not sure if this request falls within the grant guidelines. Should I still send in an application?

A: If your request is for something other than therapy, supplies, safety equipment, respite or prescribed services it will not fall within our guidelines. Please feel free to contact our office with any questions you may have.

Q: We have so many medical bills; we're having trouble paying the rent/electric/water/telephone bills. Can Hope for Three help us?

A: No. However you may be interested in looking at www.ModestNeeds.org. They are a non-profit organization that grants funding for daily living expenses in emergency situations.

Q: Where do I send my Application for Assistance?

A: Mail or drop off your application to:

Hope For Three

Attn: Quick Assist

11104 W. Airport Blvd., Ste. 150

Stafford, TX 77477

E-Mail: elizabeth@hopeforthree.org

In addition to the completed application, you will need to send the following documents:

- **Documentation of diagnosis**
- **Description of request for assistance**
- **Copy of previous year's tax return**
- **Letter(s) of recommendation (optional)**



Hope For Three

Quick Assist Application

Today's Date:	Date Funds Needed:	Amount Requested: <i>(cannot exceed \$500)</i>	
How did you hear about Hope For Three's Quick Assist Family Assistance?			
Applicant's Name:		Applicant's DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Home Address:			
City:		State:	Zip Code:
Current Diagnosis:	Diagnosed by: <i>(Name of Physician)</i>		Date of Diagnosis:
Name of Institution where Diagnosed:		Telephone Number:	
Institution address:	City:	State	Zip:
Guardian #1 Name:	Relationship:	Email Address:	
Home Phone:	Cell Phone:	Work Phone:	
Guardian #2 Name:	Relationship:	Email Address:	
Home Phone:	Cell Phone:	Work Phone:	

Consent: This form authorizes the use and/or release of the protected health information as noted in this application for purposes of the Hope for Three application review process. I give Hope for Three permission to verify treatment information by contacting the treatment vendors directly. This authorization shall be valid for one year unless otherwise stated. I understand that I may revoke this authorization in writing at any time.

Signature/Date

Supporting documentation must be attached from each service provider.

Type of Treatment	Treatment History <i>(please check one)</i>	Frequency <i>(example: 2 hrs per week)</i>	Provider of Services
Speech Therapy	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Occupational Therapy	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Physical Therapy	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Applied Behavior Analysis	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Special Diets	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Biomedical Testing	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Biomedical Intervention	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Social Skills Groups	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Auditory Intergrational Therapy:	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Respite:	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Other:	<input type="checkbox"/> Current <input type="checkbox"/> Past		
Notes:			

Notes:



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

Table with 3 columns: Income Source, Gross, Net. Rows include Income for Parent #1, Income for Parent #2, All Other Household Income, and a TOTAL row.

ASSETS

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

Do you: own your own home rent other?

HOUSEHOLD EXPENSES

Table with 4 columns for household expenses. Includes categories like House/Rent Payments, Automobile Payments, Groceries, Medical Care, etc., and a TOTAL row.



Funding Sources (including other grants or scholarship awards)

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

<input type="checkbox"/> Private/Health Insurance		
Insurance Company:	Contact Person:	Telephone Number:
Treatments Covered:		
<input type="checkbox"/> Regional Center		
Regional Center:	Contact Person:	Telephone Number:
Services Provided:		
<input type="checkbox"/> School District		
School District:	Contact Person:	Telephone Number:
Services Provided:		
<input type="checkbox"/> County		
County:	Contact Person:	Telephone Number:
Services Provided:		
<input type="checkbox"/> Other		
Describe:	Contact Person:	Telephone Number:
Services Provided:		

Description of Request for Assistance

Please describe in 200 words or less your request for assistance. Please also describe your family situation. You may use the space below or attach a separate sheet. If you attach a sheet please check this box.

Letters of Recommendation (optional)

Please attach no more than two 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.

Thank you for allowing us to "Provide Help and Create Hope."