Need Assistance?

Please read the information below to apply for Quick Assist.

Q: How much money can I request?

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

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

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

Q: Are award funds paid directly to families?

A: No. Award payments are 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 awards per month is 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 award 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 awards funding for daily living expenses in emergency situations.

Q: Where do I send my Application for Assistance?

A: Mail, e-mail or drop off your application to:

Attn: Quick Assist
Hope For Three
11104 W. Airport Blvd., Ste. 150
Stafford, TX 77477
E-Mail: samantha@hopeforthree.org

In addition to the completed application, you will need to provide 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: *(cannot exceed $500)*	
How did you hear about Hope For Three's Quick Assist?			
Applicant's Name:		Applicant's DOB:	Gender: ☐ Female ☐ Male
Home Address:			
City:		State:	Zip Code:
Current Diagnosis:	Diagnosed by: *(Name of Physician)*		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 vendors directly. This authorization shall be valid for one year unless otherwise stated. I understand I revoke this authorization in writing at any time.

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Signature *Date*

Supporting documentation must be attached from each service provider.

Type of Treatment	**Treatment History** *(please check one)*	**Frequency** *(example: 2 hrs per week)*	**Provider of Services**
Speech Therapy	☐ Current ☐ Past		
Occupational Therapy	☐ Current ☐ Past		
Physical Therapy	☐ Current ☐ Past		
Applied Behavior Analysis	☐ Current ☐ Past		
Special Diets	☐ Current ☐ Past		
Biomedical Testing	☐ Current ☐ Past		
Biomedical Intervention	☐ Current ☐ Past		
Social Skills Groups	☐ Current ☐ Past		
Auditory Integration Therapy	☐ Current ☐ Past		
Respite	☐ Current ☐ Past		
Other	☐ Current ☐ Past		
Notes:			

Income and Expenses

Awarders 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 is only used by the Family Assistance Coordinator to advocate for your child(ren)'s application based on information provided. 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	Gross $	Net $

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	$	Child Care	$
Payments/other Real Property	$	Child Support Payments	$
Automobile Payments	$	Credit Card	$
House Utilities	$	Student Loans	$
Groceries/Household Supplies	$	Other Charitable Donations	$
Medical Care (not covered by Insurance)	$	Recreation/Entertainment	$
Dental Care (not covered by Insurance)	$	Clothing	$
Auto Insurance	$	Other:	$
Life Insurance	$	Other:	$
Medical and Dental Insurance	$	Other:	$
TOTAL			

Funding Sources *(including grants or scholarships)*

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

☐ **Private/Health Insurance**		
Insurance Company:	Contact Person:	Telephone Number:
Treatments Covered:		
☐ **Regional Center**		
Regional Center:	Contact Person:	Telephone Number:
Services Provided:		
☐ **School District**		
School District:	Contact Person:	Telephone Number:
Services Provided:		
☐ **County**		
County:	Contact Person:	Telephone Number:
Services Provided:		
☐ **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. ☐

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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.