CHICAGO AUTISM NETWORK

Therapy Assistance Grant Application 2024

Thank you for your interest in our Therapy Assistance Grant program for 2024. This program is a key part of fulfilling our mission to increase access to effective autism therapies in the Chicagoland area. Funds are limited, but our board of directors will award as many grants as possible with the funding we have.

Grant Eligibility

- Applicants must have a current autism diagnosis from a MD or clinical psychologist and have a permanent address in Illinois (school screenings do not count as a diagnosis). Applicants over 18 years must have high needs in order to be eligible.
- No household can receive a Therapy Assistance Grant 2 years in a row.
- Only applicants with an annual income less than 200% of the federal poverty line may apply (see chart below)

Family Size	2023 Poverty Level	200% of 2023 Poverty Level
Individuals	$14.580	$29,160
Family of 2	$19,720	$39,440
Family of 3	$24,860	$49,720
Family of 4	$30,000	$60,000
Family of 5	$35,140	$70,280
Family of 6	$45,420	$90,840
Family of 7+	add $4,720 for each extra person	multiply total to the left by 2

Grant Process for Selected Grantees

- **If applicant has insurance** that sufficiently covers autism services, applicant may apply for up to the amount of the policy's out of pocket max, or $8,500, whichever is less.
  - If you are selected for a grant, payments will be made directly to service providers for any combination of approved therapies (see list of approved therapies on page 5). Service providers will run insurance benefits first, and then bill Chicago Autism Network the remaining amount due, up to the agreed upon amount. Please note that grant money cannot be used to cover unapproved fees, such as late/cancelation or registration fees.
  - Applicant must complete necessary intake procedures with service provider(s) and fill out necessary paperwork with Chicago Autism Network **no later than December 1st**.

- **If applicant does not have insurance**, or if applicant has insurance with insufficient therapy coverage (such as Medicaid), applicant must apply for a Marketplace Insurance Plan. Therapy Assistance Grant money will first go to cover Marketplace insurance premiums for an individual plan, and any remainder may be directed toward out-of-pocket costs for approved therapy, up to $8,500.
  - Marketplace enrollment dates are currently scheduled for November 1-December 15, 2023 After enrolling in Marketplace insurance, applicant must contact Chicago Autism Network with plan information no later than December 1st.
  - If your grant will also be going toward out-of-pocket therapy costs, payments will be made directly to service providers for any combination of approved therapies (see list of approved therapies on page 5). Service providers will run insurance benefits first, and then bill Chicago Autism Network the remaining amount due, up to the agreed upon amount. Please note that grant money cannot be used to cover unapproved fees, such as late/cancelation fees. You must complete intake procedures with service provider(s) and fill out necessary paperwork with Chicago Autism Network **no later than December 1st.**

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Application Check List

In order to be considered for a grant, please be sure to submit all of the following:

Completed application (pages 1-7)

A copy of current your 2023 tax returns **Please black out social security numbers and only send the page that verifies your income**. If you didn't file taxes in 2023, you may submit a copy of your 2022 tax return or your most recent pay stub from all sources of income.

A 1-page signed letter of recommendation from a service provider, case worker, or other individual familiar with your situation (optional, but strongly encouraged as it helps us learn more about your situation).

Submit application using one of the following methods:

- emailing a PDF copy to info@chicagoautismnetwork.org by October 1, 2023, or
- mailing a hard copy to

  Chicago Autism Network
  PO Box 804914
  Chicago, IL 60680.

  Mailed applications must be received by October 1, 2023. Because of delays in mail delivery, we highly encourage you to email your application. Every year we have applications we can't consider because of late mail delivery.
- If you are unable to use the above methods, you can email info@chicagoautismnetwork.org to set up a phone call interview, and someone from our organization will fill out the application for you.

** **Please DO NOT send extra reports or evaluations** as we will not be able to look over them.

Please note, individuals of all ages are welcome to apply. Each individual must have a separate application (siblings cannot share an application).

Grant recipients will be announced by November 15, 2023.

I ________________________________ certify that I have read the "Grant Eligibility" and "Grant Processes for Selected
(Name of individual who prepared the application)
Grantees" sections on the cover page and I understand the terms of the Grant. I also certify that the information on this application is true and correct to the best of my knowledge. I understand that falsifying any information on this application, including failure to disclose income sources, will result in the immediate termination of this grant.

Signature ____ Date ____________________

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Applicant Information

Name:	Date of Birth	Month/Year of Autism Diagnosis /
Street Address:		Ethnicity:

City	State	Zip	Gender:	Primary Language
Current School	Is current school (Check all that apply) ☐Public ☐Private ☐Therapeutic		Grade:	Does applicant have a current IEP? (Individualized Education Plan) ☐ Y ☐N

Please list services/accommodations applicant is currently receiving at school (if any)

Is applicant receiving therapy outside of school? ☐ Y ☐ N If yes, please list below:

Type of therapy	Provider	Hours/week
Type of therapy	Provider	Hours/week
Type of therapy	Provider	Hours/week
Type of therapy	Provider	Hours/week

Guardian #1

Name:	Cell Phone Number
Email address	Primary Language

Number of people living in household	Number of children under 18 living in household	Ages of others in household with ASD diagnosis (if any):

How did you hear about us?

Guardian #2

Name:	Cell Phone Number
Street Address: (If different from applicant)	Primary Language

City	State	Zip	Email Address

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Financial Information

(please attach current pay stub dated within 30 days or a copy of last year's tax returns to verify income)

Income Source #1 Current Employer	Title	Annual Income $
Income Source #2 Current Employer	Title	Annual Income $
Social Security/ SSI	Monthly Amount $	Annual Income $
Child support/Alimony	Monthly Amount $	Annual Income $
Unemployment Assistance or other income	Monthly Amount $	Annual Income $
Total Annual Household Income		(Sum of all the above boxes) $
Are your current recipients of the following assistance programs? WIC SNAP HIPP	Grant Amount Requesting (not to exceed $8,500 or insurance max out of pocket) $	

If selected as a grantee, would you like the award to cover insurance premiums, out-of-pocket costs, or a combination of both?

Insurance premiums Out of pocket costs Both

Are you receiving any other financial assistance or grants that are helping you cover therapy costs?

Yes No

If yes, please explain below (including amounts and dates):

Insurance Information

Is applicant currently insured? ☐ Y ☐ N	If currently insured, does your insurance adequately cover needed therapy services? ☐ Y ☐ N	
Current Primary Insurance Company	Check if applicable ☐ Marketplace ☐ Medicaid	Check One ☐ HMO ☐ PPO
Check One ☐ Fully Insured ☐ Self Insured*	Check One ☐ Individual Plan ☐ Family Plan	Max. out of pocket amount $
Other Insurance Company	Check if applicable ☐ Marketplace ☐ Medicaid	Check One ☐ HMO ☐ PPO
Check One ☐ Fully Insured ☐ Self Insured*	Check One ☐ Individual Plan ☐ Family Plan	Max. out of pocket amount $

*Please check with your employer or insurance company to see if you are fully-insured or self-insured. Fully insured policies follow the IL mandate to cover autism treatment. Self-insured policies don't necessarily follow the mandate.

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History

*Applicant **must have an official autism diagnosis** from an MD or Clinical Psychologist in order to apply for a grant. Informal evaluations/screeners from schools or other sources do not qualify as a diagnosis.

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the grant review process. I give Chicago Autism Network permission to verify treatment information by contacting the health care providers below. I understand that I may revoke this authorization in writing at any time.

Applicant Name ____ Date of Birth ___________________________

Guardian Name____ Relation to Applicant ___________________

Signature ____ Date ____________________

Current Diagnosis		Date of Diagnosis (Month/Year)
Name of Diagnosing Physician/Psychologist	Name of Institution/Practice	
Street Address	Phone	
City	State	Zip
Other Medical Diagnoses:		

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Grant Request

Below is a list of approved therapies that we will cover under the Therapy Assistance Grant.
Please check the support(s) for which you would like financial assistance (Check all that apply).

Speech Therapy	Occupational Therapy	Physical Therapy
ABA Therapy	Pharmacotherapy	Cognitive Behavioral Therapy
Dialectical Behavior Therapy	Other Psychotherapy	Educational/Developmental Therapy
Social Skills Groups	Therapeutic Day School	

Provider Name:			Provider Phone Number
Street Address:			Provider email
City	State	Zip	Is provider in-network with your insurance? ** ☐ Y ☐ N ☐ N/A
Are you currently receiving services from this provider? ☐ Y ☐ N			Is requested therapy covered by your insurance? ☐ Y ☐ N ☐ N/A

**Please note that we will only cover services that are in-network with your insurance. Exceptions may be made for situations where a suitable in-network provider cannot be found, but must be approved by Chicago Autism Network

Grant Request

(Fill out this box if you plan to use more than one service provider. Make additional copies of this page if necessary)

Below is a list of approved therapies that we will cover under the Therapy Assistance Grant.
Please check the support(s) for which you would like financial assistance (Check all that apply).

Speech Therapy	Occupational Therapy	Physical Therapy
ABA Therapy	Pharmacotherapy	Cognitive Behavioral Therapy
Dialectical Behavior Therapy	Other Psychotherapy	Educational/Developmental Therapy
Social Skills Groups	Therapeutic Day School	

Provider Name:			Provider Phone Number
Street Address:			Provider email
City	State	Zip	Is provider in-network with your insurance? ** ☐ Y ☐ N ☐ N/A
Are you currently receiving services from this provider? ☐ Y ☐ N			Is requested therapy covered by your insurance? ☐ Y ☐ N ☐ N/A

Personal Response

(Please use this form and do not write more than one page!)

Tell us how a Therapy Assistance Grant would benefit you/your family:

What do you hope to achieve through intensive therapy in both the short and long term?

Please tell us any other information that will be helpful for us to know about your situation.

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Authorization to Use and Disclose Protected Health Information (PHI)

(*Please complete this form for each service provider for whom you would like to receive therapy assistance. Make additional copies if necessary.)

When completed and signed by you, this form authorizes the service provider to release protected health information from your records to Chicago Autism Network.

Patient Name: ____ Date of Birth______________________

I, parent or legal guardian for the above-named child, authorize the following person(s) or institution to provide information to Chicago Autism Network, including, but not limited to the following:

- Attendance Records;
- Progress Reports;
- Session Notes; and
- Evaluations.

Service Provider Name: ____

Address: ____

Phone Number:____

This release of information is valid from September 1, 2023 to December 31, 2024.

I understand that I may revoke this Authorization at any time by sending a letter to the above service provider. However, I understand that I may not revoke Authorization for any actions taken before my receipt of written notice to revoke this Authorization. I also understand that this Authorization must be in place for me to be eligible for Therapy Assistance Grant money, and termination of this Authorization will result in termination of my grant.

I have had the opportunity to read this Authorization and agree with the statements made in this form. I understand that, by signing this form, I am confirming my authorization of use and/or disclosures of PHI described in this form.

Signature of Parent/Guardian: ____ Date: __________________

Printed name of Parent/Guardian:____

Relationship to patient: ____