

FOUNDATION FOR AUTISM CARE, EDUCATION, AND SERVICES

(F.A.C.E.S.)

Ein#20-4767823

Application for Scholarship Award

Dear Applicant:

The Foundation for Autism Care, Education, and Services (F.A.C.E.S.) is a non-profit, 501(C)3 foundation. F.A.C.E.S. is dedicated to raising funds to directly support and promote Applied Behavior Analysis (ABA) Therapy, training, and treatment for children with Autism Spectrum Disorder (ASD).

Applicants who will be considered for a scholarship must meet the following criteria:

- **Individuals** applying for a scholarship must have a child or be the legal guardian of a child formally diagnosed with ASD, have confirmed an opening for placement with the ABA Therapy Center they would like their child to attend, or be currently enrolled at an ABA Therapy Center. Individuals must be seeking a scholarship on behalf of the child because they cannot financially afford ABA Therapy. *F.A.C.E.S. will not consider an application for a child unless the parent or guardian has sought health insurance coverage for the child and still needs financial assistance. F.A.C.E.S. will not award scholarships for testing, evaluations, and/or other diagnostic purposes.*
- **Therapy Centers** applying for a scholarship must use ABA as the main therapeutic modality for children with ASD and must be requesting financial assistance solely for the cost of materials used directly for ABA Therapy within the center requesting funds.
- **Therapists, Students, and/or Parents** applying for a scholarship must be requesting financial assistance to further their education and/or training in ABA Therapy.

Please complete the attached application in its entirety and provide all requested documents. *Please pay particular attention to the request for health insurance, tax returns, and income information.* Incomplete applications will not be considered. Applicants need only to return the portion of the application pertaining to their request. A checklist is provided on page 7 to help ensure your application is complete. Please mail the completed application and all requested documents to:

F.A.C.E.S.
c/o KJ Wittmann
8823 Tweedbrook Drive
Spring, TX 77379

Thank you for your interest in F.A.C.E.S.

Sincerely,
F.A.C.E.S. Board of Directors

**F.A.C.E.S. SCHOLARSHIP APPLICATION
FOR INDIVIDUALS SEEKING FINANCIAL ASSISTANCE
FOR THE TREATMENT OF THEIR CHILD**

CHILD'S LEGAL NAME: _____

CHILD'S DATE OF BIRTH: _____

ABA TREATMENT CENTER YOUR CHILD CURRENTLY ATTENDS OR PLANS ON ATTENDING: _____

**Current enrollment or an opening for placement will be confirmed with the ABA Treatment Center prior to scholarship consideration.*

CONTACT PERSON AT ABA TREATMENT CENTER: _____

PHONE NUMBER FOR ABA TREATMENT CENTER: _____

CONTACT PERSON REGARDING INSURANCE: _____

CONTACT PERSON FOR CLIENT INTAKE SERVICES: _____

COST OF ABA THERAPY PROGRAM PER MONTH: _____

SCHOLARSHIP AMOUNT REQUESTED: _____

AMOUNT FAMILY IS ABLE TO CONTRIBUTE PER MONTH TOWARD ABA THERAPY PROGRAM: _____

**Scholarships are awarded in a manner that is most fiscally responsible for F.A.C.E.S. Scholarships may be awarded quarterly and/or annually to cover the maximum out of pocket deductible if the child's therapy is covered by insurance. This decision is made on a case by case basis by the F.A.C.E.S. Board of Directors.*

Child's Primary Insurance Plan: _____

Subscriber's Name: _____

Group Number: _____ **ID Number:** _____

Subscriber's Date of Birth: _____ **Effective Date of Insurance Coverage:** _____

Subscriber's Employer: _____

Amount insurance plan is contracted to pay toward therapy: _____

If the answer is NONE, reasons for denial of insurance coverage: _____

MOTHER'S FULL NAME: _____

MOTHER'S PRIMARY PHONE NUMBER: _____

MOTHER'S SECONDARY PHONE NUMBER: _____

MOTHER'S EMAIL ADDRESS: _____

MOTHER'S EMPLOYEER: _____

MOTHER MUST PROVIDE TAX RETURNS FOR THE LAST TWO YEARS

FATHER'S FULL NAME: _____

FATHER'S PRIMARY PHONE NUMBER: _____

FATHER'S SECONDARY PHONE NUMBER: _____

FATHER'S EMAIL ADDRESS: _____

FATHER'S EMPLOYEER: _____

FATHER MUST PROVIDE TAX RETURNS FOR THE LAST TWO YEARS

Please provide or attach a brief statement explaining why your family is requesting a scholarship from F.A.C.E.S.

If the child is insured, please provide a copy of the insurance policy and any correspondence that has occurred between you, the insurance carrier, and/or the therapy center cited in this application regarding cost/payment for ABA Therapy. If the child is covered by an additional secondary insurance policy, please provide a copy of the insurance policy and any correspondence that has occurred between you, the insurance company, and/or the therapy center cited in this application regarding cost/payment for ABA Therapy.

Please share and/or attach any information citing efforts you have sought on behalf of this child to provide funding for ABA Therapy, e.g., applications for health insurance, applications for other scholarships and/or grants, negotiated discounts with therapy providers, etc.

F.A.C.E.S. SCHOLARSHIP APPLICATION
FOR FACILITIES SEEKING FINANCIAL ASSISTANCE TO COVER THE COST MATERIALS
UTILIZED FOR ABA THERAPY

NAME OF FACILITY: _____

ADDRESS FOR FACILITY: _____

PHONE NUMBER FOR FACILITY: _____

OWNER'S NAME: _____

IS THIS ABA THERAPY CENTER NOT FOR PROFIT: YES NO

CURRENT NUMBER OF BOARD CERTIFIED BCBAs EMPLOYEED AT THIS THERAPY CENTER: _____

CURRENT NUMBER OF ABA THERAPISTS A THIS ABA THERAPY CENTER: _____

APPROXIMATE NUMBER OF CLIENTS AT THIS ABA THERAPY CENTER: _____

MONTHLY COST OF THE ABA PROGRAM AT THIS THERAPY CENTER: _____

AMOUNT THIS ABA THERAPY CENTER IS REQUESTING: _____

REASON FOR THIS REQUEST/DETAIL HOW FUNDS WILL BE USED TO DIRECTLY ENHANCE ABA THERAPY:

Facilities **must provide any financial records evidencing their need for the financial assistance for which they are applying. Please provide two (2) years of financial statements, e.g., profit/loss statements, year-end statements, balance statements and/or tax filings.*

MISSION STATEMENT FOR THIS FACILITY: _____

Please share and/or attach any information citing efforts you have sought on behalf of this facility to obtain funding for your request, e.g., applications for other scholarships and/or grants, additional fundraising activities, etc.: _____

F.A.C.E.S. SCHOLARSHIP APPLICATION

FOR STUDENTS, THERAPISTS, AND/OR PARENTS SEEKING FINANCIAL ASSISTANCE FOR FURTHER EDUCATION AND/OR TRAINING IN ABA THERAPY

FULL NAME: _____

PRIMARY PHONE NUMBER: _____

SECONDANRY PHONE NUMBER: _____

EMAIL ADDRESS: _____

FOR STUDENTS:

Are you currently enrolled in an undergraduate or graduate program? YES NO

If you answered YES, what is your current GPA? _____

Are you seeking financial assistance to enroll in a course related to ABA Therapy? YES NO

Please include course name and course number: _____

Dates/semester you will be enrolled in this course: _____

Name of institution you are attending: _____

Address of institution you are attending: _____

Name of contact who processes scholarships for students: _____

Phone number of contact who processes scholarships for students: _____

Email address for contact who processes scholarships for students: _____

Cost per semester hour: _____ Cost to enroll in this course: _____

Scholarship amount requested: _____

STUDENTS MUST PROVIDE A COPY OF THEIR MOST RECENT TRANSCRIPT

**Scholarships are awarded in a manner that is most fiscally responsible for F.A.C.E.S. Scholarships for students are awarded quarterly, but students may reapply if additional financial assistance is needed. Scholarships are granted on a case by case basis by the F.A.C.E.S. Board of Directors.*

FOR THERAPISTS AND/OR PARENTS:

Name of Workshop/Training you wish to attend: _____

Date of Workshop/Training: _____

Location of Workshop/Training: _____

Cost of Workshop/Training: _____

Amount you are requesting to assist with the cost of Workshop or Training: _____

THERAPISTS/PARENTS MUST PROVIDE A COPY OF REGISTRATION FORM FOR THE WORKSHOP/TRAINING

Are you currently employed at a facility that provides ABA Therapy? YES NO

If YES, name of Employer: _____

Contact Person/Supervisor: _____

Phone Number for Contact Person/Supervisor: _____

How long have you been employed at this facility? _____ Start date: _____

Job Title: _____

If you have any additional information or documentation that you believe would assist F.A.C.E.S. in evaluating your application, please attach to this application.

APPLICANT ACKNOWLEDGEMENT

With the submission of this application, the applicant, in their individual capacity and, if applicable, as representative as legal guardian of a child, or representative of a facility, understands:

- A complete application and the requested documents are necessary to be considered for financial assistance.
- There is no guarantee of financial assistance.
- Scholarships are awarded in a manner that is most fiscally responsible F.A.C.E.S. This decision is made on a case by case basis and determined by the F.A.C.E.S. Board of Directors.
- Scholarships may be awarded quarterly and/or annually to cover the maximum out of pocket deductible if the child's therapy is covered by insurance. Any amount awarded is based on the foundation's evaluation of the application and documentation, and the amount of funds available to the foundation at the time of the request.
- Any scholarship awarded to the applicant will be paid directly to the ABA Therapy Center, institution of higher learning, or directly to the sponsoring organization for conferences pertaining to training or continuing education which supports ABA Therapy.

In addition, if an applicant is awarded a scholarship on behalf of F.A.C.E.S., the recipient must adhere to the following guidelines and stipulations:

- If any information provided within this application changes, the applicant will supplement the application with the updated information immediately upon receiving said information, e.g., change in health insurance coverage, change in financial circumstances, change in ABA Treatment Center as noted in this application.
- If the applicant's need for requested funds ceases prior to donated funds being utilized, the applicant will notify F.A.C.E.S. immediately and arrangements will be made with the ABA Therapy Center, institution of higher learning, or sponsoring conference/organization to return all unnecessary funds.
- Scholarships will be awarded in a manner that is most fiscally responsible for F.A.C.E.S. and used solely to further the purposes of F.A.C.E.S. as expressed in this application.
- If awarded a scholarship, the recipient agrees to allow F.A.C.E.S. to use the name of the recipient, pictures of recipient, and/or statements provided by the recipient on our F.A.C.E.S. website, promotional videos, and material that advertises and promotes the foundation.

I, _____, acknowledge that I have completed this application to the best of my ability. I have included all requested documents and understand that I must adhere to the guidelines and stipulations sited within this application. Failure to follow these guidelines and stipulations may result in the loss of any current and/or future funding opportunities provided by F.A.C.E.S.

Printed Name of Applicant: _____ Date: _____

Signature of Applicant: _____

CHECKLIST

FOR INDIVIDUALS SEEKING FINANCIAL ASSISTANCE FOR THE TREATMENT OF THEIR CHILD, PLEASE BE SURE YOU HAVE COMPLETED AND INCLUDED THE FOLLOWING:

- PGS. 2, 3, & 6
- COPIES OF TAX RETURNS FOR THE LAST TWO YEARS
- COPY OF INSURANCE POLICY OR POLICIES
- COPY OF ANY CORRESPONDENCE THAT HAS OCCURRED BETWEEN YOU, INSURANCE CARRIERS NOTED, AND/OR THERAPY CENTER CITED IN THIS APPLICATION

FOR FACILITIES SEEKING FINANCIAL ASSISTANCE TO COVER THE COST MATERIALS UTILIZED FOR ABA THERAPY, PLEASE BE SURE YOU HAVE COMPLETED AND INCLUDED THE FOLLOWING:

- PGS. 4 & 6
- FINANCIAL RECORDS FOR THE LAST TWO YEARS EVIDENCING NEED FOR THE FINANCIAL ASSISTANCE FOR WHICH YOU ARE APPLYING, E.G., PROFIT/LOSS STATEMENTS, YEAR-END STATEMENTS, BALANCE STATEMENTS AND/OR TAX FILINGS.

FOR STUDENTS, THERAPISTS, AND/OR PARENTS SEEKING FINANCIAL ASSISTANCE FOR FURTHER EDUCATION AND/OR TRAINING IN ABA THERAPY, PLEASE BE SURE YOU HAVE COMPLETED AND INCLUDED THE FOLLOWING:

- PGS. 5 & 6
- **STUDENTS:** COPY OF MOST RECENT TRANSCRIPT
- **THERAPISTS AND/OR PARENTS:** COPY OF REGISTRATION FORM FOR WORKSHOP/TRAINING YOU ARE SEEKING FINANCIAL ASSISTANCE TO ATTEND