ACT Today
Autism Care & Treatment Today
Grant Program Notice

ACT Today's goal is to introduce and help facilitate early and on-going treatment by providing the necessary resources including funding, guidance, referrals and follow up to individuals with Autism Spectrum Disorders and their families. ACT Today is proud to offer a grant program for assessment and treatments that may not otherwise be covered privately or by other third-party funding sources such as school districts, county programs, insurance, and/or other grant making entities.

Applicants who meet the following grant program criteria and complete the Grant Application will be considered for ACT Today grants. Since in most cases, the applicant's parent or guardian will be completing the application, it is understood that the applicant will be the individual receiving the benefits of the grants.

Grant Making Philosophy
Act Today grants are designed to provide financial support to individuals and families affected by Autism Spectrum Disorders. **Grant payments will be made directly to pre-approved treatment providers, assessors or materials vendors.**

Amount Requested
Grants will be allocated based on annual fundraising activities. The Board of Directors will determine the number and amounts of each grant at the beginning of each term. Requests for endowments or multi-year grants will not be accepted and grant recipients must re-apply each term.

- Applicant must demonstrate financial need by providing the following:
  - Household income
  - # of Dependants
  - # of Dependants with Autism Spectrum Disorders
  - Information about access to third-party funding sources
- The following must be sent to ACT Today in order to be eligible for grants:
  - Completed, signed and dated Grant Application
  - Verification of Diagnosis
  - Documentation from Provider of Treatment/Assessment of Costs
  - 200 Word Description of current family situation
  - Copy of Previous Years Tax Returns
- The Board Members will review Grant Applications and make decisions on who should receive grants
- Grant Application must be postmarked no later than the deadline date specified
- No Faxed or Emailed Grant Applications will be accepted
- Grant Applications must be mailed to:

ACT Today
c/o Gretchen Jacobs, Esq.
2375 E. Camelback Rd., Suite 700
Phoenix, AZ 85016

Applicant receiving a grant agrees to repay the grant if any services paid for with the grant are reimbursed by another funding source, such as, a school district or insurance company.

Grant applications must include specified information. Incomplete Grant Applications will not be considered.

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ACT Today
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Grant Application

Please type or print clearly in the form below.

Today's Date: ___________________________

How did you hear about ACT Today's Grant Program? (Please list name if referred by a person)

____

General Information

Applicant's Name (Child affected by Autism Spectrum):		Applicant's Date of Birth:
Applicant's Current Age:		Applicant's Gender ☐ FEMALE ☐ MALE
Street Address:		
City:	State:	Zip Code:
1) Guardian #1 Name:		Relationship
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address:	
2) Guardian #2 Name:		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address:	

Dependent/Sibling Information			**Autism Spectrum Disorder Diagnosis**
Name:	Age:	Relation to Applicant:	☐ YES ☐ NO
Name:	Age:	Relation to Applicant:	☐ YES ☐ NO
Name:	Age:	Relation to Applicant:	☐ YES ☐ NO
Name:	Age:	Relation to Applicant:	☐ YES ☐ NO

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History

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the ACT Today grant review process. I give ACT Today 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:

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

Treatment

Type of Treatment	**Treatment History** (please check one)	**Frequency** (example: 2 hrs per week)	**Provider of Services**
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		
Other: (please explain)	☐ Current ☐ Past ☐ Not applicable		
Other: (please explain)	☐ Current ☐ Past ☐ Not applicable		
Other: (please explain)	☐ Current ☐ Past ☐ Not applicable		
Other: (please explain)	☐ Current ☐ Past ☐ Not applicable		
Other: (please explain)	☐ Current ☐ Past ☐ Not applicable		

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Grant Funds Request

Check all that apply, complete requested information and include copies of supportive documentation, such as, letters of support from service providers, service/intervention descriptions, treatment cost sheets, provider brochures, receipts, etc.

☐ Direct Treatment

Total Cost of Treatment $	Grant Amount Requested for Treatment: $	Supportive Documentation Attached: ☐ Yes ☐ No (if "No" application will not be considered)
Grant Request is for the following Service/Intervention(s)		
Provider Name:	Provider Contact Telephone Number:	
Street Address:		
City:	State:	Zip Code:

Describe details: (Include who will provide treatment, frequency and duration of treatment, etc.)

☐ Assessments or Testing

Total Cost of Assessment/testing: $	Grant Amount Requested for Assessment/Test(s): $	Supportive Documentation Attached: ☐ Yes ☐ No (if "No" application will not be considered)
Grant Request is for the following Service/Intervention(s)		
Provider Name:	Provider Contact Telephone Number:	
Street Address:		
City:	State:	Zip Code:

Describe details: (Include who will provide testing at what frequency and purpose)

☐ Materials

Total Cost of Assessment(s): $	Grant Amount Requested for Assessment(s): $	
Grant Request is for the following Service/Intervention(s)		
Provider Name:	Provider Contact Telephone Number:	
Street Address:		
City:	State:	Zip Code:

Describe details: (Include reason materials required)

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Financial Information

Guardian #1 Monthly Gross Income:	$	Please attach copy of previous year's Tax Return
Guardian #2 Monthly Gross Income:	$	Please attach copy of previous year's Tax Return
Other Sources of Income: Source:		
Monthly Gross Amount:	$	
Source:		
Monthly Gross Amount:	$	

Funding Sources (including other grants or scholarship awards)
Check all funding sources that apply and complete the requested information.

☐ **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:		
☐ **Other**		
Describe:	Contact Person:	Telephone Number:
Services Provided:		

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Description of Family Situation

Please describe in 200 words or less your family situation. You may use the space below or attach a separate sheet. If you attach a separate 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's situation. Letters of recommendation are optional and should be no more than one page in length.

FOR OFFICE USE ONLY

Diagnosis Verification	☐ Yes	☐ NO
Treatment Verification	☐ Yes	☐ NO
Support Documents to Verify Costs	☐ Yes	☐ NO
Assessment Verification	☐ Yes	☐ NO
Copy of Previous Year's Tax Return Submitted	☐ Yes	☐ NO
200 Word Description of Situation Submitted	☐ Yes	☐ NO

ACT Today Board Review

☐ Approved ☐ Declined - Reason: ____________________

Amount Approved: **$**	Date Applicant Notified:	Board Approved Signature:	Date:

Comments/Notes:

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