The Spectrum of Hope Foundation
Advocacy Grant Application

_____ _____ _____

Your Name (Last, First, Middle Initial) **Your Date of Birth** **Your Social Security No.**

_____

Home Address (Street, City, State, Zip Code)

_____ _____ _____

Home Telephone **Business/Other Telephone** **Email address**

I am applying for this advocacy grant to assist me with: (check one)

__Independent education evaluation __ Special education advocacy __Autism therapy expenses

Tell us about your family

1. Do you have a child with autism spectrum disorder living with you? ___ YES ___ NO

If Yes, Name of child _____ His/ Her Date of Birth _____

2. Do you have more than one child with autism living with you? ___YES ___ NO
(If Yes, and you would like to apply advocacy grants for the other child(ren), please submit a separate application for each child.)

3. Have you been a resident of California for over a year? ___ YES ___ NO

Tell us about your finances

1. Is your combined family income LESS THAN $70,000 (AGI) <u>for the last calendar year</u>?
___YES ___NO (*Please provide a copy of last year's 1040 Federal Income Tax Return form*)

2. What is your total monthly income (including any government assistance)? _____
3. What are your total monthly expenses? (Please list them below.)

_____

_____

4. If you have any other debt, please list them below:

_____

5. Do you have health insurance for your child you are applying this grant for? ___YES ___NO

Type of Insurance: _____

Tell us about your child's services

1. The name of your child's school district: _____

2. Do you receive services from your school district? ___YES ___NO
Please list the services and the frequency:

_____

3. Do you receive services from your Regional Center? ___YES ___NO
Please list the services and the frequency:

_____

4. Have you filed for due process hearing against your school district over service issues?
___YES ___NO If so, please briefly describe the issues

_____

5. Have you filed for fair hearing against your Regional Center over service issues?
___YES ___NO If so, please briefly describe the issues

_____

Your request for assistance

1. Have you ever received assistance from the Spectrum of Hope Foundation before?
___YES ___NO If so, please note when: _____

2. Amount requested for the Grant: _____ **(Not to exceed $1,000.00)**

4. All information submitted to us shall remain CONFIDENTIAL. Please note that, pursuant to California and federal law requirements, we reserve the right to follow up and conduct random audit to ensure any approved grant was actually used for its intended purposes.

5. Funding of the grant is in full and absolute discretion of the Foundation and we may decline your application for ANY REASONS. WE DO NOT GUARANTEE FUNDING OF ANY APPLICATIONS. The Foundation has discretion not to notify the applicants who were not selected for the Grant. All decisions made are final and are not subject to review or appeal.

6. If the Grant is approved, we may issue a check payable to your professional vendor and mail it to your address as provided in this application. Alternatively, we may issue a check payable to you only in which case you agree to provide the Foundation with a receipt /invoice from the vendor(s) as soon as you receive it, but no later than 30 days of the actual receipt. This is to ensure that the Grant is spent as stated in the application.
7. Please note that this Grant is to assist you with the current or upcoming expense, and is not meant to be used as a retroactive reimbursement of expenses incurred in the past (i.e., you

cannot submit application for expenses which incurred more than 30 days prior to the date of the application.)

8. If the Grant is approved, and you use it to fund the services or assessment which is later reimbursed by the school district, the Regional Center or health insurance company, you agree to return the grant money to the Foundation within the 30 days of the reimbursement.

9. Your circumstance may be featured in our website (www.spectrumhope.org) to show the type of work we do to the potential donors. We will not use your personal, private or otherwise identifying information such as your name, age, address, etc. but we may describe your circumstance in general term to solicit donation so we can continue serving the families in need.

I agree to all the terms and conditions set forth in this application and certify that the information on this form is true and complete to the best of my knowledge.

X _____ _____

Applicant' signature **Date**

Please include the following with the completed application:

1. Proof of autism diagnosis; if you suspect your child has autism and are trying to establish a diagnosis of autism for the Special Education / Regional Center eligibility, please provide us with a summary describing your unique situation.

2. Previous year's tax return (IRS Form 1040),

3. A copy of invoice, estimates, quotes or other documentation from the vendor(s) for the service(s) for which you plan on paying with the Advocacy Grant,

4. Any supporting document to show your hardship which will be helpful in our decision-making process, and

5. Application Summary: This advocacy grant is **need-based.** On a separate sheet of paper, please describe your unique hardship and why you need this grant money. Please share with us your extenuating circumstances that should be considered in our selection process, e.g., your child's unique challenges/ your financial situation, etc.

And email the soft copy of completed application to
info@spectrumhope.org

If you don't have access to email, you can mail the completed application package to:

The Spectrum of Hope Foundation
1038 E Bastanchury Rd # 255 Fullerton, CA 92835

Thank you!