Aid for Autistic Children Foundation, Inc.
Help • Hope • Heal

Box 141
Macon, Georgia 31202
478-471-4941

## Application for Financial Assistance or Debt Relief

**AACF, Inc. encourages you to apply for financial assistance or debt relief if you need help paying for autism related hospital bills, therapies, early intervention, adult late intervention or any obstructive debt resulting from decisions made in an effort to structure one's life routine around care for an autistic child or loved one. Under this program, AACF, Inc. can provide a grant based on your eligibility and income. You can get financial assistance even if you have insurance. Simply answer the following questions carefully. Please do not leave anything out.**

### Personal Information

Applicant Name: _____
Mailing Address: _____
Telephone Number(s): Home: _____ Work: _____

List below the people in your household. Please list the dollar amount of the total monthly income that supports the household. Include money that is earned (paychecks, profits, interest, savings) as well as income that is not earned (welfare, unemployment, child support, gifts, grants).

| | Name | Birth Date | Relationship | Monthly Income |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |

### Health Insurance Information

Medical Insurance? Yes _____ No _____
If "yes" print name of insurance company: _____
Policy Number: _____
Other coverage? Yes _____ No _____ Please identify other coverage: _____
Medicare _____ Medicaid _____

**Financial Information**

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?

Yes _____ No _____ If yes, please describe: _____
_____
_____
_____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property?)

Yes _____ No _____ If yes, please explain: _____
_____
_____
_____
_____
_____

Has your child, children, or loved one been diagnosed with autism ***and*** other competing medical conditions for which they may need coaching, medication, dietary intervention or therapy? (for example, ADHD, ADD, OCD, etc.) See note below.*

Yes _____ No _____ If yes, please list the medical condition(s) and chosen treatment: _____
_____
_____
_____
_____
_____

If your child, children or loved one is receiving additional treatment, are the coaching, medical, dietary and therapeutic expenses incurred payed out of pocket, provided for free or covered by insurance?

Out of pocket _____ Free _____ Insurance provider: _____
_____

* If you answered "Yes" and your child, children or loved one is NOT receiving medication, dietary intervention or therapy for their competing medical conditions, simply state "Not receiving treatment at this time". Also include any social skills coaching for children with Asperger's Syndrome.

**Patient Worksheet:**

**Net Monthly Income:** Please indicate all source of income.

| | |
|---|---|
| Patient/Guarantor: | $_____ |
| Spouse: | $_____ |
| Other income: | $_____ |
| **Total Net Monthly Income:** | **$_____** |

**Monthly Expenses:** Please indicate your average monthly expenses for the following items.

| | |
|---|---|
| Food: | $_____ |
| Utilities: | $_____ |
| Auto/Gas: | $_____ |
| Telephone: | $_____ |
| Childcare: | $_____ |
| Other: _____ | $_____ |
| Other: _____ | $_____ |
| **Total:** | **$_____** |

**Creditors:** Please indicate the amount of all monthly payment and to whom the payment is made.

| | |
|---|---|
| Rent/Mortgage: _____ | $_____ |
| Insurance (Auto): _____ | $_____ |
| Insurance (Other): _____ | $_____ |
| Other payment: _____ | $_____ |
| Other payment: _____ | $_____ |
| Other payment: _____ | $_____ |
| Other payment: _____ | $_____ |
| **Total:** | **$_____** |

I understand that the information I am giving will be verified by Aid for Autistic Children Foundation, Inc. and reviewed by the board of directors, state and/or federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____ Date _____

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Mail this application with all documentation to:

Aid for Autistic Children Foundation, Inc
Administration
Box 141
Macon, Georgia 31202

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## INFORMATION

Be sure to include with your application documents that give the income amounts you list. For example:

- Pay stubs from all employment or
- A W-2 withholding statement or
- Last year's income tax return or
- Letters approving or denying Medicaid, medical assistance, other benefits or
- Letters approving or denying unemployment compensation or
- Written statements from employers or welfare agents.

Financial assistance and charitable grants are generally secondary to ALL other financial resources available to you or your autistic child(ren). This may include:

- Group or individual medical plans
- SSI
- Medicare
- Medicaid
- Medical assistance programs
- Other state, federal, or military programs

Financial assistance and charitable grants shall be limited to “direct debt relief” as defined in the Aid for Autistic Children Foundation, Inc.'s Articles of Incorporation and mission statement.

Financial assistance and charitable grants shall be limited to 150,000 USD in total debt relief per household. Household's requesting less than 150,000 USD will remain qualified to access their remaining balance of debt relief funds if, in the future, they show cause for the need.

All applications for financial assistance and charitable grants are subject to majority approval by Aid for Autistic Children Foundation, Inc.'s board of directors. We reserve the right to deny assistance to any who fraudulently attempt to obtain funds through the falsification of documentation or other such deceptive statements or actions.