

Eddie Guardado Foundation

Grant Application

The Eddie Guardado Foundation's (EGF) goal is to help you manage the costs of early and on-going Autism treatment programs by providing the necessary resources including funding, guidance, referrals and follow up to individuals with Autism Spectrum Disorders and their families. EGF is proud to offer a grant program for assessments and treatments that may not otherwise be covered privately or by other third-party funding sources such as school districts, county programs, private insurance, Medicaid and/or other grant making entities. Applicants who meet the following grant program criteria and complete the Grant Application will be considered for EGF 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 payments will be made directly to pre-approved treatment providers, caregivers, assessors or materials vendors.

Grant Application Criteria

Please carefully read the criteria. Applications submitted that do not meet the criteria will not be considered. In evaluating applications, the EGF Board will consider applications based on the following criteria:

1. Grant applications requesting assistance for dental or orthodontic treatment unrelated to a serious medical condition are excluded from grant consideration.
2. The applicant must be 17 years old or younger and live in the United States.
3. The applicant must be covered by a commercial health benefit plan and limits for the requested service are either exceeded, OR no coverage is available, AND/OR the co-payments are a serious financial burden on the family. A commercial health benefit plan is defined as follows:
 - Your commercial (private) employer. Example: most grant applicants whose parent works for a commercial entity will have this type of health insurance.
 - Your health benefit plan is offered through a commercial health plan that you individually purchased. Example: small business owners, sole-proprietors, etc.
 - Your health benefit plan is offered through your employment with a town, city, state or federal government. Example: teachers, police officers, active duty or civilian military duty, etc.
4. The applicant may be covered under Medicaid, Medicare, SCHIP (which may be called various names by each state), HIS or other state or federally subsidized health insurance programs given to those without insurance or with low incomes.
5. The potential of the intervention to significantly enhance either the clinical condition or the quality of life for the child, the financial status of the family and the severity of the child's illness. If a grant is approved, services must be provided by a trained, and if appropriate, licensed professional.
6. Financial need of the child's family will be evaluated and documented through information provided on the application and by submission of a photocopy of the most recently filed Federal tax return (Internal Revenue Service 1040, 1040-A, or 1040-EZ). Awards will NOT be granted to individuals in families whose **Adjusted Gross Income (AGI) exceeds \$20,000 per family member**. For example, if you are a family of three and your most recently filed IRS 1040 indicates that your AGI is \$60,001 or more, you are not eligible.
7. Other financial resources to meet the health care need are not available.
8. **The amount awarded to an individual within a 12-month period is limited to either \$5,000 or 85% of the fund balance, whichever amount is less. Awards to any one individual are limited to a lifetime maximum of \$7,500.**
9. An application must be submitted prior to the child's 17th birthday.
10. The health care professional is to be paid directly; exceptions can be made to reimburse the family if adequate documentation is submitted showing the health care professional has been paid.
11. Applications are to be reviewed by a health care professional appointed by the Foundation to determine the medical appropriateness of the treatment.
12. An application must be submitted to the Foundation prior to the receipt of services. The Foundation

does not pay for past medical expenses.

13. Applicants who are not approved by the EGF Board must wait a period of twelve months before re-applying, unless the medical condition and requested items have significantly changed from the original request.
14. In order to apply for your child, the child must live with you 51% or more and be listed as a dependent on your most recently filed IRS 1040. If the child is not listed on your most recently filed IRS 1040, then we need a copy of both your most recently filed IRS 1040 and the most recently filed IRS 1040 on which the child is listed as a dependent.
15. If a grant is approved, you cannot re-apply for another grant until 30 days before your current grant expires. Yearly and lifetime maximum grant limits apply.

Amount Requested

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

Applicants must demonstrate financial need by providing the following:

- Proof of Household Income
- # of Dependents
- # of Dependents with Autism Spectrum Disorders Information about access to third-party funding sources

The following must be sent to EGF 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 Applications must be post marked no later than the deadline date specified

No Faxed or Emailed Grant Applications will be accepted

Grant Applications must be mailed to:

EGF
Attn: Grant Committee
1100 Irvine Blvd #334
Tustin, California 92780

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.

Eddie Guardado Foundation Grant Application

Please type or print clearly in the form below.

Today's Date: _____

How did you hear about EGF's Grant Program? (please list name if referred by a person)

Have you previously applied for an EGF grant? No Yes, Date _____ Outcome _____

General Information

| | | | |
|---|--------|---|--|
| Applicant's Name (Child effected 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: | |

Dependant/Sibling Information

Autism Spectrum Disorder Diaanosis

| 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 |
| Name: | Age: | Relation to Applicant: | YES | NO |

History

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

Date of Diaanosis:

Diagnosed by: (Name of Physician)

Name of Institution where Diaanosed:

Telephone Number:

Street Address:

City:

State:

Zip Code:

Treatment

| Type of Treatment | Treatment History (please check one) | Frequency (example: 2hrs 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 Testina | 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 | | |

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: | Zip Code: |
| Describe details: (Include reason materials required) | |

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: | | |

