Child Therapy Financial Aid Application
4th Quarter 2022
Application Deadline: December 2, 2022

APPLICANT (Parent/Guardian) NAME AND ADDRESS INFORMATION

*Enter the requested information of the **parent/guardian who is submitting** the Bluestone VOICES for Autism Child Therapy Financial Aid application.*

Last Name: First Name:

Address: Apt./Unit #:

City: State: Zip:

Cell phone: Landline phone:

email:

CHILD's INFORMATION

*Enter the applicable information for **the child for whom the financial aid is being requested** .*

Name: Date of Birth:

Child's ABA Center Name & Address: (note – if child not yet receiving services attach physician letter confirming diagnosis)

ABA Center Name:

Address: Suite/Unit #:

City: State: Zip:

Center Email: Webiste URL:

Phone:

*Identify the **therapy services** the child is receiving.*

Therapy Services Received:	YES	NO	
ABA			
Occupational			
Speech			
Other			Therapy:
Other			Therapy:

INSURANCE INFORMATION

If no Secondary Insurance coverage, enter N/A under Secondary Insurance Co. name.

Primary Insurance Co. Name:

Address:

Suite/Unit #:

City:

State:

Zip:

Secondary Insurance Co. Name:

Address:

Suite/Unit #:

City:

State:

Zip:

*Enter requested insurance **coverage sums** and current **YTD sums expended** ; enter N/A if no Secondary Insurance Co. provider.*

APPLICANT's FINANCIAL OBLIGATION	**PRIMARY INSURER**	**SECONDARY INSURER**
Annual Deductible		
YTD Deductible Used		

APPLICANT's FINANCIAL OBLIGATION	PRIMARY INSURER	SECONDARY INSURER
Maximum Annual Coinsurance/Copay		
YTD Coinsurnce/Copay Used		
Maximum Annual Out of Pocket (OoP)		
YTD OoP Used		

APPLICANT FAMILY / HOUSEHOLD INFORMATION

*List all household members **expect Applicant and Child** ; relationship information is as the member is **related to the Child** (i.e., mother, father, sibling, grandparent, etc.)*

Full Name:		Relationship:		Age or DOB:	
Full Name:		Relationship:		Age or DOB:	
Full Name:		Relationship:		Age or DOB:	
Full Name:		Relationship:		Age or DOB:	
Full Name:		Relationship:		Age or DOB:	

FAMILY EMPLOYMENT INFORMATION

*Enter requested employer(s) information & expected **annual gross income** for parent(s)/guardian(s); enter **N/A** if there is no 2nd parent/guardian or the 2nd parent/guardian is not employed.*

	Parent/Guardian #1 (APPLICANT)	Parent/Guardian #2
Current Employer:		
Position:		
Annual Gross Pay:		

HOUSEHOLD's ESTIMATED MONTHLY CASH FLOW ASSESSMI

*Enter estimated **total monthly net income & expenditures** obtained from all household members. If income/expenditure is not monthly (example: weekly, semi-monthly paycheck, semi-annual property tax, quarterly water bill) **use calculated monthly equivalent** .*

TOTAL ESTIMATED MONTHLY INCOME		ESTIMATED MONTHLY EXPENES	

***As applicable** , include the following:*

- *> Net monthly salary*
- *> Military Benefits*
- *> SSI / SSDI*
- *> Unemployment*
- *> Workman Compensation*
- *> Structured Settlement: e.g., monthly alimony and/or child support payments.*

***As applicable** , include the following:*

- *> Mortgage / Rent*
- *> Property Tax*
- *> Household Utilities: electricity, natural gas/propane, water, telephone/cable/internet, etc.*
- *> Insurance: home, renters, auto, medical, life, disability, personal liability, etc.*
- *> Transportation: auto loan, gasoline, all forms of public transportation, etc.*
- *> Structured Settlement: e.g., monthly alimony and/or child support expenditures.*

REASON FOR APPLYING FOR BVA FINANCIAL AID:

How did you hear about Bluestone VOICES for Autism?

To be considered for a 4th Quarter 2022 Bluestone for VOICES Autism Child Therapy Financial Aid award, this completed, signed application ***and the following documents*** must be submitted ***no later thanDecember 2, 2022*** , either by mailing to: Bluestone VOICES for Autism, 38935 Ann Arbor Rd., Suite 150, Livonia, MI 48150 OR send via secure email: bluestonevoicesforautism@gmail.com

>> Most recent **paystub** for each employed household member identified in FAMILY EMPLOYMENT INFORMATION

>> Most recent **IRS 1040**

>> If applicable (see CHILD's INFORMATION section) physician letter confirming Child's diagnosis

APPLICANT'S CERTIFICATION AND AGREEMENT

By signing this Bluestone VOICES for Autism Financial Aid application, I certify that the information on this form is true and complete to the best of my knowledge.

I authorize Bluestone VOICES for Autism (BVA) to share the financial data in this application with the members of its Board and with all other persons and entities BVA believes, in its sole discretion, are material to the decision to award this financial assistance. I release BVA from any and all claims based in any way on sharing or releasing the financial data in this application, and on sharing or releasing all other financial data provided to BVA in connection with this application. This waiver includes, but is not limited to, claims for financial or other damages based on unauthorized disclosure of, or mishandling of, the data described in this paragraph.

I acknowledge that prior to receiving a Bluestone VOICES for Autism Financial Aid award, parent/guardian is required to sign a Release Authorization Form which requires recipient and family to maintain contact with BVA for a minimum of one (1) year and consent to the use of recipient's name, story, photos, etc. to be used for BVA promotional purposes.

Applicant Signature:		**Application Date:**	
Disposition:	**Approved: Yes / No**	**Decision Date:**	
Award Amount:		**Award Paid Date:**	