



The Special Education Advocacy Grant Application

Your Name (Last, First, Middle Initial) Date of Birth Social Security Number

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 (*mark and circle ones that apply to you*):

- Independent Evaluation on _____
- Special Education Advocacy (*Attorney/ Advocate* *Expert-witness fee*)
- Autism Therapy Expense (*ABA* *Speech*)

Tell us about your family

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

If Yes, Name of child _____ 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. Are you a resident of California? YES NO

If Yes, for how long? _____

Tell us about your finances

1. Is your combined family income LESS THAN \$70,000 total for the last calendar year?
 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 family? YES NO

Type of Insurance: _____

Tell us about your child's services

1. The name of your 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 Advocacy 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 Advocacy 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 Advocacy 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 Advocacy 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.spectrumofhope.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 based on need. On a separate sheet of paper, please describe your unique hardship and why you cannot pay for the particular services. 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 mail the completed application package to:

The Spectrum of Hope Foundation
17128 Colima Road, #116
Hacienda Heights, CA 91745

Alternatively, you may email the soft copy of completed application package to info@spectrumofhope.org

Thank you.