



APPLICATION PACKET

Quarterly Grant Schedule

<p><u>Winter Quarter</u> Deadline for Applications: December 1st Grants Awarded: January 2nd Coverage Begins: January 1st</p>	<p><u>Spring Quarter</u> Deadline for Applications: March 1st Grants Awarded: April 1st Coverage Begins: April 1st</p>	<p><u>Summer Quarter</u> Deadline for Applications: June 1st Grants Awarded: July 1st Coverage Begins: July 1st</p>	<p><u>Fall Quarter</u> Deadline for Applications: September 1st Grants Awarded: October 1st Coverage Begins: October 1st</p>
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Checklist for Submission of Application

Applications will not be accepted if the following checklist is not fully complete.

	Have you fully completed your child's Questionnaire?
	Have you included a photocopy of your child's insurance card(s) or medical coupon?
	Have you included a <u>fully</u> executed Authorization to Release Information to The ISAAC Foundation?
	Have you included a <u>fully</u> executed Autism Spectrum Disorder Diagnosis Form or other appropriate diagnosis documentation?

Revised 10/20/10

APPLICANT QUESTIONNAIRE

Child's Name:	Child's DOB:	Age:
Parent/Guardian's Name:		
Address:		City:
State:	Zip:	Phone No:
Email Address:		

INSURANCE INFORMATION

Insurance Carrier:	Subscriber Name:	
Subscriber DOB:	Group No:	
Policy No:		
Are you required to meet a deductible before services are covered?		
Amount of Deductible:		
Do you pay a co-pay per therapy visit?	Amount of co-pay:	
Do you pay co-insurance per therapy visit?	%	%
	Your portion	Insurance Portion
Does this insurance carrier provide coverage for your child's therapy needs?		
Does this insurance carrier cap the number of visits you may receive each year?		
If so, how many visits are you allowed to receive each year?		
Do you have secondary insurance? (If yes, please provide the above shaded information for secondary insurance carrier on a separate sheet of paper and attach to your application submission.)		
Is your child eligible to receive services from the 0-3 Infant Toddler Network?		
Name of Case Worker:		

****Please provide a copy of the front and back of your insurance card(s) or medical coupon. Your application will not be considered complete without this attachment.**

MEDICAL HISTORY

Child's Diagnosis:	
Name of Physician giving diagnosis:	Phone No:
Pediatrician's Name:	Phone No:

EDUCATION

Does your child attend private or public school?	
Name of school:	
Are any therapy services provided by school?	
Type:	Minutes per week:
Type:	Minutes per week:
Type:	Minutes per week:

THERAPY HISTORY

Name of therapy provider:	Phone No:
Type of therapy received:	
Minutes per session:	Frequency of visits:
Are you currently receiving services from this provider?	
What is your out-of-pocket expense to see this provider (per visit)?	

Name of therapy provider:	Phone No:
Type of therapy received:	
Minutes per session:	Frequency of visits:
Are you currently receiving services from this provider?	
What is your out-of-pocket expense to see this provider (per visit)?	

THERAPY HISTORY (CONTINUED)

Name of therapy provider:	Phone No:
Type of therapy received:	
Minutes per session:	Frequency of visits:
Are you currently receiving services from this provider?	
What is your out-of-pocket expense to see this provider (per visit)?	

Name of therapy provider:	Phone No:
Type of therapy received:	
Minutes per session:	Frequency of visits:
Are you currently receiving services from this provider?	
What is your out-of-pocket expense to see this provider (per visit)?	

Name of therapy provider:	Phone No:
Type of therapy received:	
Minutes per session:	Frequency of visits:
Are you currently receiving services from this provider?	
What is your out-of-pocket expense to see this provider (per visit)?	

What is the amount of your average monthly out-of-pocket expenses for your child's therapy after insurance pays their portion? (Include co-pays, co-insurance, uncovered therapy expenses, supplements, student workers, etc.)
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ADDITIONAL INFORMATION

Do you or members of your household practice therapy techniques with your child in your home?

How many hours per week do members of your family spend working with your child using these therapy techniques?

Describe your therapy activities with your child:

Describe your child's communication skills:

Describe your child's social skills:

Circle the statement that you believe best describes your loved one:

My child is mildly affected by autism

My child is moderately affected by autism

My child is profoundly affected by autism

What are your child's greatest challenges?

What are your child's greatest gifts?

GRANT INFORMATION

What type of therapy grant are you interested in receiving?
(Must be one of the therapy modalities listed on The ISAAC Foundation list of approved interventions.)

Why are you interested in trying this therapy intervention for your child?

Has your child used this therapy intervention in the past?

Why does your family need this grant?

REFERENCES (may be personal or medical)

Name:	Relationship:
Phone No.:	

Name:	Relationship:
Phone No.:	

Name:	Relationship:
Phone No.:	

Please return the enclosed questionnaire to:

The ISAAC Foundation

P. O. Box 19202

Spokane, WA 99219

Information provided in this questionnaire is for the exclusive use of grant determination by The Isaac Foundation.

This information will not be disclosed unless specifically requested by a Law Enforcement Agency or as required by law.

AUTHORIZATION TO RELEASE INFORMATION TO THE ISAAC FOUNDATION

Patient Name: _____
Date of Birth: _____

AUTHORIZATION

- You may contact the healthcare providers of the above referenced patient and obtain all healthcare information including those specifically related to psychiatric/mental health disorders.
- Specifically include the following: _____
- All healthcare information except: _____

INFORMATION TO BE RELEASE FROM:

Name of Insurance Carrier: _____
Address: _____ City: _____ State: _____ Zip: _____

Name of Medical Provider: _____
Address: _____ City: _____ State: _____ Zip: _____

Name Medical Provider: _____
Address: _____ City: _____ State: _____ Zip: _____

Name Medical Provider: _____
Address: _____ City: _____ State: _____ Zip: _____

INFORMATION TO BE PROVIDED TO:

THE ISAAC FOUNDATION
P. O. Box 19202
Spokane, WA 99219
(509) 499-1679

holly@theisaacfoundation.org

MY RIGHTS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I may revoke this authorization in writing. If I do, it would not affect any actions already taken by THE ISAAC FOUNDATION based upon this authorization. I understand that once the healthcare information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

Relationship to Patient: _____

~~This Authorization will expire 90 days from the date signed~~

You may accept a photocopy of this Authorization with the same authority as the original. This Authorization complies with the Health Insurance Portability and Accountability Act (HIPPA)



Autism Spectrum Disorder Diagnosis Form

Patient Name: _____

Date of Birth: _____

I am the (pediatrician / medical physician / developmental pediatrician / psychologist / psychiatrist) treating the above-referenced patient. At the present time, the above-referenced patient is currently diagnosed with an autism spectrum disorder of _____ (i.e. Pervasive Developmental Disorder (PDD), Autism, Asperger's Syndrome).

Signature: _____ Date: _____

Typed Name: _____

The above-referenced patient is applying for a therapy grant from The ISAAC Foundation. In order to qualify for financial assistance, the patient must provide medical documentation demonstrating that the patient's current diagnosis is an Autism Spectrum Disorder. Information provided in this **Autism Spectrum Disorder Diagnosis Form** is for the exclusive use of The ISAAC Foundation for grant eligibility. This information will not be disclosed unless specifically requested by a Law Enforcement Agency or as required by law.

Please return to:
The ISAAC Foundation
P. O. Box 19202
Spokane, WA 99219