



APPLICATION PACKET

Quarterly Grant Schedule

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

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 8/28/09

APPLICANT QUESTIONNAIRE

Child's Name:	Child's DOB:
Parent/Guardian's Name:	
Address:	
Phone No:	
Email Address:	

INSURANCE INFORMATION

Insurance Carrier:	Subscriber Name:
Subscriber DOB:	Group No:
Policy No:	
Does this insurance carrier provide coverage for your child's therapy needs?	
Secondary Carrier:	Subscriber Name:
Subscriber DOB:	Group No:
Policy No:	
Does this insurance carrier provide coverage for your child's therapy needs?	
Is your child eligible to receive services from the 0-3 Infant Toddler Network?	
Name of Case Worker:	
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.)	
Does your insurance company cap the number of visits you are allowed for therapy services for your child per year?	
If so, how many visits are you allowed per year?	

****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:

THERAPY HISTORY

Name of therapy provider:	Phone No:
Type of therapy received:	
Number of Sessions per week:	
Are you currently receiving services from this provider?	

Name of therapy provider:	Phone No:
Type of therapy received:	
Number of Sessions per week:	
Are you currently receiving services from this provider?	

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Type of therapy received:	
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Name of therapy provider:	Phone No:
Type of therapy received:	
Number of Sessions per week:	
Are you currently receiving services from this provider?	

EDUCATION

Name of school child currently attending:	
Are any therapy services provided by school?	
Type:	Number of Sessions per week:
Type:	Number of Sessions per week:
Type:	Number of Sessions per week:

REFERENCES (may be personal or medical)

Name:	Relationship:
Phone No.:	

Name:	Relationship:
Phone No.:	

Name:	Relationship:
Phone No.:	

GENERAL

What type of current therapy services that you are receiving would you like to increase, if any?
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What types of therapy services are you interested in receiving for your loved one but are unable to obtain financially?

Why does your family need this grant?

How would you describe your loved one applying for this scholarship?

What qualities do you most admire in your loved one?

Please return the enclosed questionnaire to:

The ISAAC Foundation
P. O. Box 1954
Airway Heights, WA 99001
holly@theisaacfoundation.org

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 1954
Airway Heights, WA 99001
(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.