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| Heart of Texas Autism Networka 501(c )3 nonprofit corporationEIN 26-3590691

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| **25**4-733-8965 | PO Box 2484Waco TX 76703 | [www.hotan254.org](http://www.hotan254.org)info@hotan254.org |

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 ***Application for Assistance Form***

 **Name Relationship to child Annual Income**

**Guardian/Self:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:** **State:** **Zip:** \_\_\_\_\_\_\_\_\_\_\_

**County:**  (HOTAN serves all of the 254 area code which includes: McLennan and Bell County areas)

**Telephone #: Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**: **Primary Language:** \_\_\_\_

\_\_\_ please check if you***do not***want to be added to the HOTAN email list.

***Referred By***: \_\_\_\_\_\_\_\_\_\_\_

Do you or your child receive Star Kids or Star Plus Medicaid? Yes No

Do you or your child have insurance? Yes No

Do you or your child have a diagnosis of Autism? Yes No

Do you or your child receive SSI? Yes No

**Please give specifics about crisis/need, amount requested as well as other support or resources already involved or you have contacted for help. Please include how this support will impact your or your child’s life:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please Note:** This application is not a guarantee of assistance. Funds are distributed based on eligibility factors and on available funds. Eligibility factors can include but are not limited to: residents in the 254 area code (McLennan and adjacent counties) of Central Texas, exhausted all other resources/programs and not receiving Medicaid/Medicare services that would otherwise cover need requested. H*OTAN representatives reserve the right to ask further clarifying questions before processing your request, if needed! HOTAN’s assistance program is a reimbursement process and HOTAN will require proof of need and at times proof of payment you will need reimbursement for. HOTAN will review each request and decide support amount each month on the 3rd Thursday of the month. Your re request if granted will be processed at the beginning of the following month at the very latest.*

*If you are requesting such services as rental assistance, food assistance, utility assistance etc. or services covered by your insurance or Medicaid/Medicare plan……..….please be advised that HOTAN representatives may request verification that you have attempted to access these services before consideration in processing your request*.

**Place a check in the blank next to each of the services below that could be helpful for your family:**

\_\_\_ Respite (Break for parents through in-home or

 Center-based child care)

\_\_\_ Family activities

\_\_\_ Summer Activities, Camps

\_\_\_ Community Resources

\_\_\_ Support groups

\_\_\_ Home/Vehicle modifications

\_\_\_ Medicaid Waiver Programs

\_\_\_ Medical equipment or supplies

\_\_\_ Medicaid transportation program

\_\_\_ Legal Questions

\_\_\_ ABA therapy

\_\_\_ Special Education

\_\_\_ Medical/Medicaid

\_\_\_ SSI/SSDI

\_\_\_ Personal Care Services

\_\_\_ Dental \_\_\_

\_\_\_ Diapers

\_\_\_ Mental Health/Counseling

\_\_\_ English for Speakers of Other Languages (ESOL))

\_\_\_ Training

\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Parent/Guardian Signature Date