Medical Insurance Grant Application for the 2022 Calendar Year

Our Vision

Prepare kids with autism for the world and prepare the world for them.

Our Mission

To be the financial bridge to help children on the autism spectrum that are uninsured or underinsured access medical insurance coverage in order to attain Applied Behavior Analysis (ABA) Therapy. ABA Therapy focuses on communication, life and social skills and helps individuals reach their full potential. We strive to create a world of inclusion, where ALL means ALL.

Important Information for Applicants

- Applicants **MUST** have a current autism diagnosis.
- Applicants **MUST** be a resident of Illinois.
- Applicants can be on MEDICAID, uninsured or have existing medical insurance.
- Applicants Household income and size will be taken into consideration (Priority will go to low income and/or families with multiple dependents on the spectrum.)
- Applicants **MUST** complete a *Personal Statement* explaining their need for assistance (page 8).
- If awarded, applicants can use their medical insurance grant for any and all therapies and medical needs but we **ONLY** audit for ABA Therapy.
- One application per applicant. (All family members and siblings **MUST** have their own application).
- Applicants **MUST** be seeking Applied Behavior Analysis (ABA) Therapy with a **MINIMUM of 12 HOURS Weekly.** (We require that all grantees maintain twelve (12) hours at minimum of ABA per calendar week).
- **Applicants should please note that new health insurance plans typically require that your dependent's autism diagnosis be within the last three (3) years or may require that you get an updated evaluation in order to be applicable for ABA services.**
- Applicants may be contacted for a phone interview or emailed to obtain more information.
- Applications **MUST** be received no later than **MIDNIGHT (No Exceptions)** along with your **2020 TAX RETURN AND TWO OF YOUR MOST RECENT PAY STUBS OR UNEMPLOYMENT PAY STUBS FROM YOUR APPLICATION DATE.**

****FAILURE TO INCLUDE ALL SOURCES OF INCOME ON APPLICATION INCLUDING SELF-EMPLOYMENT CAN DISQUALIFY YOUR APPLICATION. Email your application and all documents to applications@autismheroproject.org**

GRANT RECIPIENTS WILL BE NOTIFIED PRIOR TO DECEMBER 12TH, 2021

If applicant does NOT have medical insurance or has medical insurance through their employer, the state, or Medicaid that DOES NOT cover Applied Behavior Analysis (ABA) Therapy, applicant may apply with the understanding that:

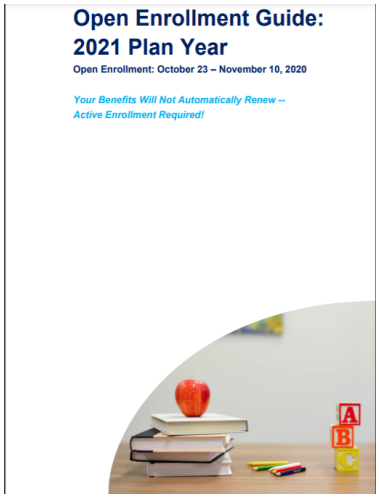
- Applicants with **MEDICAID MUST** apply for health insurance through a **PRIVATE INSURANCE BROKER** and **NOT** from *The Marketplace* otherwise known as the *Affordable Health Care Act.* ***(*This is necessary because The Marketplace is a government subsidized health insurance plan and insureds are NOT allowed to have more than one type of government subsidized insurance plan. If you make this mistake, MEDICAID will automatically cancel. Additionally, it is important to note that private insurance will become your primary insurance and MEDICAID will be a secondary insurance.)***
- All other applicants ***without*** medical insurance or medical insurance that ***does not*** specifically cover ABA Therapy **can** apply for health insurance that will cover ABA Therapy from a private insurance

broker or The Marketplace at https://www.healthcare.gov **(**The Marketplace allows for premium tax credits based on income where attaining insurance from a private insurance broker may not.)**

- Open enrollment period for 2022 coverage is November 1-December 15, 2021 for January 1st, 2022 start date, otherwise open enrollment will remain open through January 15th, 2022.
- Marketplace recommended plans are Silver or Gold due to deductible and out-of-pocket maximum.**IT makes it seem like **BRONZE IS THE MOST AFFORDABLE MONTHLY BUT LONG-TERM CAN BE THE MOST COSTLY BECAUSE OF DEDUCTIBLE, COPAYMENTS AND COINSURANCE.**
- Our Medical Insurance Grant covers medical insurance premiums for an individual plan with evidence that ABA Therapy is ongoing and occurring in the month with an average minimum of twelve (12) hours weekly.
- ABA Audits will occur a minimum of four (4) times throughout the year to verify therapy is taking place.
- Applicants will send AHP their monthly insurance premium invoice for reimbursement within 30 days of invoice date along with evidence that the monthly premium payments are being paid on time. AHP will not pay any late fees or other fees of any kind. **Both are required in ONE email to** be sent to applications@autismheroproject.org

Applicants who DO have medical insurance through their employer that DOES cover ABA Therapy.

- AHP will pay the difference in coverage that covers the applicant's portion of premium **ONLY**. (For Example: If **Employee** premium is $75 per pay period for medical insurance and **Employee plus a dependent** premium is $125. AHP will pay the difference of coverage for the applicant in the amount of $50 ($125 - $75 = $50). Another example for an **Employee** that carries a family plan. **Employee** premium is $75 per pay period for medical insurance and the family plan premium is $125. AHP will pay the difference of coverage for the applicant in the amount of $50 ($125 - $75 = $50).
- When completing an application if you have your Employee 2022 "Open Enrollment Plan Guide", please use the most current employee portion payroll deductions for insurance. (*We have provided a sample of a 2021 Open enrollment guide to help you understand where your grant application amounts should be pulled from.)
- ABA Audits will occur a minimum of four (4) times throughout the year to verify therapy is taking place.
- Applicants will send AHP evidence that monthly premium payments are being paid through employer deductions on the current pay stubs.



MEDICAL PLAN OPTIONS

Contributions for Employees

Coverage Tier by Plan	Annual Cost			Employee Contribution Per Deduction	
	Annual Premium	District Portion	Employee Portion	26 Pay Periods	21 Pay Periods
Silver + HSA					
Employee only	$5,064	$4,304	$760	$29.23	$40.00
Employee plus spouse	$10,381	$8,824	$1,557	$59.88	$81.95
Employee plus children	$8,710	$7,403	$1,307	$50.27	$68.79
Family	$14,433	$12,268	$2,165	$83.27	$113.95
Dependent Veteran Child	$5,064	$0	$5,064	$194.77	$266.53
PPO Plan					
Employee only	$9,959	$8,465	$1,494	$57.46	$78.63
Employee plus spouse	$20,417	$17,354	$3,063	$117.81	$161.21
Employee plus children	$17,130	$14,560	$2,570	$98.85	$135.26
Family	$28,384	$24,126	$4,258	$163.77	$224.11
Dependent Veteran Child	$9,959	$0	$9,959	$383.05	$524.17
Gold + HSA					
Employee only	$10,314	$8,767	$1,547	$59.50	$81.42
Employee plus spouse	$21,144	$17,972	$3,172	$122.00	$166.95
Employee plus children	$17,740	$15,079	$2,661	$102.35	$140.05
Family	$29,395	$24,986	$4,409	$169.58	$232.05
Dependent Veteran Child	$10,314	$0	$10,314	$396.69	$542.84
Dental Plan					
Employee only	$663	$663	$0	$0.00	$0.00
Employee plus spouse	$1,359	$663	$696	$26.76	$36.63
Employee plus children	$1,140	$663	$477	$18.36	$25.12
Family	$1,889	$663	$1,226	$47.16	$64.53
Dependent Veteran Child	$663	$0	$663	$25.50	$34.89
Vision Plan					
Employee only	$92	$46	$46	$1.76	$2.41
Employee plus spouse	$174	$87	$87	$3.34	$4.57
Employee plus children	$182	$91	$91	$3.52	$4.81
Family	$268	$134	$134	$5.17	$7.07
Dependent Veteran Child	$92	$0	$92	$3.52	$4.81

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PLEASE SHARE HOW DID YOU HEAR ABOUT US? _____

APPLICANT INFORMATION

Full Name **Gender: M ☐ F ☐**			**Date of Birth (MM/DD/YYYY)**
Street Address (Include apartment number)			**Social Security or ITIN Number**
City	**State**	**Zip**	**Date of Autism Diagnosis**
School	**Current School: ☐ Therapeutic ☐ Public ☐ Private**		**Grade: (If applicable)**
Ethnicity (Check all that apply) __American Indian or Alaskan __Asian __Black or African American __Hispanic or Latino __White			**Primary Language**
Current ABA Provider	**ABA Address, Contact Person and Phone Number**		

GUARDIAN #1

Full Name		**Social Security or ITIN Number**	**Cell Phone:** **Alternate #:**
Address		**City**	**State & Zip**
Relationship	**Email Address**		**Occupation**
Employer Name	**Employer Address**		**Employer Phone Number**
Number of people living in household?	**Number of children under 18 living in household? Any person over 18 please list relationships.**		**Ages of other individuals in household with ASD (If any):**

GUARDIAN #2

Full Name		**Social Security or ITIN Number**	**Cell Phone:** **Alternate #:**
City		**State**	**Zip**
Relationship	**Email Address**		**Occupation**
Employer Name	**Employer Address**		**Employer Phone Number**
Number of people living in household?	**Number of children under 18 living in household? Any person over 18 please list relationships.**		**Ages of other individuals in household with ASD (If applicable)**

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HISTORY

Consent: This form authorizes the use and/or release of the **Protected Health Information (PHI)** as noted below for purposes of the grant review process. I give ***The Autism Hero Project*** permission to verify treatment information by contacting the health care providers below. I understand that I may revoke this authorization in writing at any time.

Applicant Name _____ Date of birth _____

Guardian Name _____ Relationship to applicant _____
Signature _____ Date _____

Current Diagnosis (es) if more than just Autism	**Date of Autism Diagnosis**
Name of Diagnosing Physician	**Name of institution/Practice**

Street Address	**Phone**

City	**State**	**Zip**

Other Medical Diagnoses (If applicable)

Financial Information

(You MUST attach the 2 most current pay stubs or unemployment stubs for each guardian and from each employer dated within 30 days AND a copy of 2020 tax returns to verify income.)

Guardian # 1	**List Every Current Employer(s)**	**Annual Income** **$**
Guardian #2	**List Every Current Employer(s)**	**Annual Income** **$**

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Other household Income	Total Amounts: (Please Circle)
☐ Child Support ☐ SSI ☐ Alimony/maintenance payments ☐ Unemployment Income ☐ Other _____ Name other income not mentioned above including SELF – EMPLOYMENT or HOBBY income. Please Specify: _____	$_____ Monthly / Annually $_____ Monthly / Annually $_____ Monthly / Annually $_____ Monthly / Annually $_____ Monthly / Annually $_____ Monthly / Annually $_____ Monthly / Annually
Comments: (Anything that we should know or that you want to explain.)	Total Income $ _____ Monthly / Annually
Are you current recipients of the following assistance programs? (circle) WIC: Y / N SNAP $_____ OTHER: _____ $_____	Grant Amount requesting (Total for Monthly Health Insurance Premiums NOT DEDUCTIBLES):
If The Autism Hero Project is unable to fund your entire request, are you interested in partial assistance? YES ☐ NO ☐	Are you receiving any other financial assistance or grants that are helping you cover therapy costs, health insurance or deductibles? (Please check all that apply and amount.) YES ☐ NO ☐ Amount for each: $_____ HIPP ☐ United Healthcare ☐ Chicago Autism Project ☐ Chicago Autism Network ☐ ☐ Other: Please list _____
Anything we should know regarding this financial assistance grant? (Please comment below)	

Primary Insurance Information

Is the applicant currently insured? Yes_____ NO _____	If applicant is currently insured mark "X" on the type of insurance: ___Employer Plan ___Marketplace ___ State ___ Medicaid
Primary Insurance Company	If applicant is NOT currently insured, please confirm that you have applied for insurance through <u>The Marketplace</u> before open enrollment closed Dec. 15th___YES __NO Plan: (Circle One) Bronze Silver Gold

Insurance Phone Number	ID#	Group#
Deductible Amount	Maximum Individual out of pocket (Write family maximum amount if a family plan.)	
Secondary Insurance Company	ID#	Group#
Insurance Phone Number	Maximum Individual out of pocket (Write family maximum amount if a family plan).	

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Therapy(s) your child HAS or IS currently receiving (Circle all that apply): *Make additional copies of this page if you are CURRENTLY receiving therapy from more than 3 providers.*

ABA THERAPY	SPEECH THERAPY	SOCIAL SKILLS GROUPS
THERAPEUTIC DAY SCHOOL	FLOOR TIME	COGNITIVE BEHAVIORAL THERAPY
DEVELOPMENTAL THERAPY	PHARMACOTHERAPY	SOCIAL WORKER
PHYSICAL THERAPY	PSYCHOLOGIST	OTHER _____
FOOD THERAPY	OCCUPATIONAL THERAPY	OTHER _____

Current Provider Name		**Provider Phone Number**	
Street Address		**Provider E-Mail**	
City	**State**	**Zip**	**Is provider in network with your insurance? YES / NO**
Type of therapy **Hours per Week**		**Is requested therapy covered by your current insurance?**	
Current Provider (2) Name		**Provider Phone Number**	
Street Address		**Provider E-Mail**	
City	**State**	**Zip**	**Is provider in network with your insurance? YES / NO**
Type of therapy **Hours per Week**		**Is requested therapy covered by your insurance?**	
Current Provider (3) Name		**Provider Phone Number**	
Street Address		**Provider E-Mail**	
City	**State**	**Zip**	**Is provider in network with your insurance? YES / NO**
Type of therapy **Hours per Week**		**Is requested therapy covered by your insurance?**	

Authorization to Use and Disclose Protected Health Information (PHI)

(*Please complete this form for each ABA Service Provider for whom you would like to receive therapy assistance. Make additional copies if necessary.)

When completed and signed by you, this form authorizes the service provider to release **P**rotected **H**ealth **I**nformation from your records to The Autism Hero Project.

Patient Name: _____ **Date of Birth: _____**

I, _____parent or legal guardian for the above-named child, authorizes the following person(s)or institution to provide information to *The Autism Hero Project*, including not limited to the following:

- Attendance Records
- Progress Reports
- Session Notes
- Evaluations

Service Provider Name: _____

Address: _____

Phone Number: _____

This release of information is valid from *Now through December 31st, 2022.*

I understand that I may revoke this authorization at any time by sending a letter to the above provider. However, I understand that I may not revoke authorization for any actions taken before my receipt of written notice to revoke this authorization. I also understand that this authorization must be in place for me to be eligible for Therapy Assistance Grant money, and termination of this authorization will result in termination of my grant.

I have had the opportunity to read this authorization and agree with the statements made in this form. I understand that, by signing this form, I am confirming my authorization of use and/or disclosure of PHI described in this form.

Signature of Patient (if over 18): _____ Date _____

Signature of Parent or Guardian: _____ Date _____

Printed Name_____ Relationship to patient: _____

Personal Statement

(Statements can be typed or written in English or Spanish)

Help us get to know your family situation better and your need for assistance. What is your hope with ABA Therapy? Please tell us any other information that you think would be helpful for us about your situation.

(Please limit your statement to a maximum of one-page front and back.)

AFFIDAVIT

(TO BE COMPLETED BY GUARDIAN OF APPLICANT)

I, _____ certify that the information provided on this application is true and correct to the best of my knowledge. I understand that falsifying any information on this application, including failure to disclose income sources, will result in the immediate termination of this grant.

Printed Name _____

Signature _____

Date _____

Application Checklist

In order to be considered for a grant, please be sure to submit all of the following:

- □ Completed Application (pages 3-9)
- □ **Signed** *History Consent* (page 4)
- □ **Signed** *Authorization to Use and Disclose Protected Health Information (PHI)* (page 7)
- □ Personal Statement – 1 page maximum (page 8)
- □ **Signed** *Affidavit* (page 9)
- □ Last 2 current pay stubs (dated within 30 days) for all parents / guardians. If Self-Employed please provide proof of income and expenses in the last 30 days.
- □ 2020 Tax Returns for parents / guardians ***If you do not have income or income taxes please indicate No Tax Return or Pay Stubs when you submit your application.**
- □ Applicants seeking insurance in 2021 from The Marketplace must complete the information below.

Submit application, pay stubs and 2020 tax returns using one of the following methods:

- Email a copy in one PF to **applications@autismheroproject.org** by November 15th, 2021 or
- Mail hard copies to:
  The Autism Hero Project
  2612 Pond View Drive
  Algonquin, IL 60102
- All mailed applications must be postmarked by *November 15th, 2021.*

Please Note: All Applicants may be contacted to conduct a phone interview.

GRANT RECIPIENTS WILL BE NOTIFIED PRIOR TO DECEMBER 12TH

FOR APPLICANTS THAT ARE SEEKING 2022 MEDICAL INSURANCE FROM THE MARKETPLACE

The Marketplace Insurance Information for 2022		
Is the applicant currently insured from The Marketplace? **Yes_____ NO _____** **Will applicant renew current plan from The Marketplace?** **Yes_____ NO _____**	**For 2021, The applicant will be seeking:** (Mark the plan and enter the number (#) of the plan name and type.) **__ Bronze HMO Plan # ____ ___ Bronze PPO Plan # _____** **__ Silver HMO Plan # ____ ___ Silver PPO Plan # _____** **__ Gold HMO Plan # ____ ___ Gold PPO Plan # _____**	
Primary Insurance Company and Address	**Estimated Monthly Premium: $_____** **Deductible: $_____** **Out-of-Pocket Maximum: $_____**	
Insurance Phone Number	**ID#**	**Group#**