

**Please complete your proposal using our online grants management portal (instructions located on the foundation’s website). This PDF is for informational purposes only.**

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| **APPLICATION OVERVIEW INFORMATION** |
| Project Title (*please leave blank*)  Anticipated Session Start Date  Anticipated Session End Date  Name of Professional Providing Treatment  Title of Professional Providing Treatment  Who Referred the Child to You:  Name  Relationship to Child  Phone  Email  Child’s Details:  Child’s Initials  Birth Date  Age  Current Grade Level  Address  County  School Details (*if child is school-aged, please complete this section regardless of whether it is the school or a different entity applying*):  Name of Classroom Teacher/Service Provider  Phone and Contact Information  School Name (*if applicable*)  Public or Private School (*if applicable*)  Does the child qualify for reduced lunch? (*if applicable*) |

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| **FINANCIAL INFORMATION** | |
| **Treatment Costs** | Therapist’s Usual Fee Per Session  Session Fee Discount  Total Number of Sessions  Total Cost  Total Family Contribution  Other Financial Sources  Amount Requested  Family Annual Net Salary  Describe why this family cannot afford their child's therapy or treatment.  Does your organization accept Medi-Cal and/or do you have an EPSDT contract for the service for which you are applying?  Does your client receive Medi-Cal benefits?  If your client is covered by Medi-Cal for this service, and/or your organization accepts Medi-Cal or has an EPSDT contract, please explain why you are applying for this grant from AFW. |
| **Payment Information** | Grant to be Paid to:  Federal Tax ID#  Grant letter to be sent to the attention of:  Name and Title  Organization  Address  Phone  Email |

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| **PROPOSAL REQUEST** |
| *Please note that the word limits on the following narrative questions are maximum. We encourage you to be as brief and concise as you see fit.*   |  |  | | --- | --- | | Organization/Provider  Overview  **(*400 Words*)** | In this section describe: 1) the type of services provided, 2) the population generally served by the organization/provider, 3) the name, qualifications, degrees/licenses of the person providing treatment, and 4) the organization’s/provider’s policies on serving families unable to meet the cost of service.  *For new applicants*: please include contact information for two professional references. | | Profile of Child  **(*400 Words*)** | Provide a brief overview of the child in relation to this request for treatment, as well as the child’s motivation to participate in treatment. | | Profile of Family  **(*400 Words*)** | Provide a brief overview of the family and home environment, as well as the family’s motivation to support the child’s treatment. | | Treatment History  **(*200 Words*)** | Has the child been in treatment for this condition previously? If so, 1) state with who and for how long, 2) explain why a continuation of treatment is necessary, and 3) explain why the family can no longer afford treatment. | | Diagnosis and Description  **(2*50 Words*)** | State the diagnosis/deficit being addressed, when it was first detected, and provide a brief description. | | Assessment/Test Results  **(*300 Words*)** | Has the child been assessed? If so, 1) provide a brief overview, 2) attach the test results, IEP, or any other pertinent documents to the application under Documents, and 3) state when the assessment occurred. | | Goals  **(*300 Words*)** | 1) Describe the goals, and 2) describe the measureable outcomes that will be used to assess progress throughout the course of this intervention. | | Treatment Plan  **(*500 Words*)** | 1) Summarize the therapies/treatments/modalities that will be used to achieve the goals stated above.  2) Include approximate number of sessions per week, time needed to accomplish goals, and any additional stipulations. Maximum one year.  3) Do you expect to achieve the goals in the given timeframe? Explain why. | | Other Factors  **(*200 Words*)** | State other factors that may influence the results of the planned treatment. | |

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| **THERAPY SPECIFIC QUESTIONS**  *Please only answer the questions that are applicable to the type of request you are submitting: Remedial Education, Speech, Occupational and Physical Therapy ONLY or Psychotherapy ONLY.* |
| **REMEDIAL EDUCATION, SPEECH THERAPY, OCCUPATIONAL AND PHYSICAL THERAPY ONLY** |
| Has the child been enrolled in an Individual Education Program within the school district? If so, please describe program and progress or outcome, and attach a copy. ***(200 Words)***   |  |  | | --- | --- | | What is your assessment of intellectual performance as it relates to the child’s grade, age, or developmental level?  ***(200 Words)*** | | |  | | | Please enter in the approximate grade/age/developmental level for the following skills: | | | Word recognition | Written expression | | Reading comprehension | Math calculation | | Listening comprehension | Math problem solving | | Oral expression | Gross motor skills | | Articulation | Fine motor skills/handwriting | | Spelling |  | |

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| **PSYCHOTHERAPY ONLY** |
| Are the parents/guardians in therapy? If so, please describe the type of therapy. **(*200 Words*)** |

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| **DOCUMENTS TO UPLOAD** *(Please note that all documents must be uploaded as PDFs)* |
| |  | | --- | | 1. Release of Information Form (*signed by parent, guardian, or youth if over 18*) 2. Family Income and Expense Form 3. W9 Form (*for professionals in private practice only*) 4. At least one letter of support from another professional who is involved in the case and not associated with the service provider submitting the application (i.e., doctor, teacher, social worker, etc.) 5. Relevant test results, assessment findings, and/or IEPs (*if applicable*) | |