



## SCHOLARSHIP GUIDELINES AND PROCEDURES

**Application deadline: March 24, 2017**

The HALO Foundation is a 501(c)3 Registered Public Nonprofit Corporation (EIN: 45-3822537) uses dance to help not only autism awareness, but will raise funds to pay for treatment to families that could not afford this treatment without outside assistance and financial contributions.

Our Scholarship Program for 2017 is through an application process that will be distributed throughout the country for children from ages 1 to 18 years old. It is imperative for early intervention in young children with autism continued specialized treatment for children with autism. The HALO Foundation can provide the financial support to lower income families by helping with financial assistance to pay for these therapies.

### **ELIGIBILITY:**

Scholarships for 2016 will range between \$1,000-\$4,000 per family and the student must live in The United States to be eligible. The HALO Foundation is a separate CA Nonprofit Corporation and is not affiliated with Newport-Mesa Unified School District or any other organization. The applicant can be between 1-18 years of age as of December 31, 2017.

Selection would be made based on financial need and high expected effectiveness of treatment. Parents are able to discuss on their scholarship application why they deem this service necessary and how this will directly help their individual child. Services could include, but are not limited to: ABA, Speech, RDI, DIR/Floortime, NAET, Biomedical Intervention Therapy, DAN doctors, OT, PT, Animal Assisted Therapy, and Music Therapy.

The Scholarship Selection Committee consists of HALO Board of Directors, community leaders, and autism treatment professionals. Employees, Scholarship Selection Committee, and Board Members of HALO are NOT eligible for scholarships. The selection committee who select recipients will not derive any private benefit, directly or indirectly, from the selection of applicants.

The individual applicant who will benefit from the scholarship must have a diagnosis of an autism spectrum disorder (autism, PDD-NOS, Asperger's, etc).

Upon completion of the program or service funded by the scholarship, the recipient must provide information about the success or the program or service.

Scholarships are provided without regard to race, color, religion, creed, national or ethnic origin, sex or marital status.

**PROCEDURES:** \* Complete all sections of the application for consideration.

Please attach to the application:

- Copy of recent federal income tax return for you and/or spouse if applicable
- Copy of most recent W-2 for you and/or your spouse if applicable
- Copy of medical diagnosis or complete IEP.

Mail applications to:

**HALO Foundation - 1835 Newport Blvd A109 – 248 Costa Mesa, CA 92627**

Scholarship recipients will be notified via email and a check will be written directly to the service provider.

Questions can be addressed to: [info@halodance4autism.org](mailto:info@halodance4autism.org)

**WWW.HALODANCE4AUTISM.ORG**



# FINANCIAL AID SCHOLARSHIP APPLICATION

2017 Applications must be received by Mar 24, 2017 at:  
HALO 1835 Newport Blvd. A109-248 Costa Mesa, Ca 92627

\_\_\_\_\_  
Name of Applicant who will benefit from this scholarship      Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

\_\_\_\_\_  
Diagnosis (e.g. autism, PDD-NOS, Asperger's, etc)      Date of diagnosis \_\_\_\_\_

\_\_\_\_\_  
Name and professional credential of person who made this diagnosis (eg, MD, PhD, MSW, etc)

\_\_\_\_\_  
Name(s) of Parents(s) or Guardians(s)      Home Phone \_\_\_\_\_

\_\_\_\_\_  
Street Address      Cell or alternate phone \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip      E-Mail Address \_\_\_\_\_

\_\_\_\_\_  
Marital/relationship status of parents or guardians      # of minor children including applicant \_\_\_\_\_

\_\_\_\_\_  
Occupation of father or guardian      Employer name and phone number \_\_\_\_\_

\_\_\_\_\_  
Occupation of mother or guardian      Employer name and phone number \_\_\_\_\_

Please provide a detailed description of the services for which you seek financial aid. Please also list the name of the service provider with the address and phone number including a contact person. If you are chosen, the HALO Foundation will pay the service provider directly. Attach additional pages as needed.

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

Provider: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Provider address: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Provider email address (if known): \_\_\_\_\_

Total cost of program \$ \_\_\_\_\_

*\* If you are selected, the HALO Foundation will award a maximum contribution equal to the granted scholarship amount.*

**FINANCIAL INFORMATION**

Please itemize your monthly household, pre-tax income, and expenses.

**MONTHLY INCOME**

Gross Wages, Salary & Tips	\$ _____
Spouses Gross Wages, Salary & Tips	\$ _____
Aid to Dependent Children	\$ _____
Unemployment Compensation	\$ _____
Social Security and/or Disability	\$ _____
Child Support	\$ _____
Housing Allowance	\$ _____
Food Stamps/CAL Fresh	\$ _____
Retirement Income (non Social Security)	\$ _____
Other Income	\$ _____
<i>TOTAL MONTHLY INCOME</i>	\$ _____

**MONTHLY EXPENSES**

Rent or Mortgage	\$ _____
Utilities	\$ _____
Food	\$ _____
Clothing	\$ _____
Car Expenses (gas, insurance, loan, etc)	\$ _____
Other Transportation Expenses	\$ _____
Medical Insurance	\$ _____
Medical Expenses	\$ _____
Other Expenses	\$ _____
<i>TOTAL MONTHLY EXPENSES</i>	\$ _____

**HOME OWNERSHIP AND OTHER ASSETS AND LIABILITIES**

Do you own your home and/or other real estate? Yes\_\_\_\_ No\_\_\_\_

*\* If yes, please list each piece of real estate separately with its approximate value.*

Primary home value \$\_\_\_\_\_ Total mortgages/loans against property \$\_\_\_\_\_

Other real estate value \$\_\_\_\_\_ Total mortgages/loans against property \$\_\_\_\_\_

Do you rent your home? Yes\_\_\_\_ No\_\_\_\_ If yes, what is your monthly rent? \$\_\_\_\_\_

Amount in checking and savings account \$\_\_\_\_\_

Total amount in **RETIREMENT ACCOUNTS** like IRAs, 401k, 403B, etc. List each account and approximate balance as of the latest valuation date.

_____	\$_____	_____	\$_____
_____	\$_____	_____	\$_____
_____	\$_____	_____	\$_____

List other significant **ASSETS**:

_____	\$_____	_____	\$_____
_____	\$_____	_____	\$_____

List other significant **LIABILITIES** you owe, for example credit cards.

_____	\$_____	_____	\$_____
_____	\$_____	_____	\$_____

**OTHER CONSIDERATIONS**

Medical Insurance coverage:

Company and coverage type \_\_\_\_\_ Monthly Premium \$\_\_\_\_\_

Will your medical insurance pay for any of the services described in your request? Yes\_\_\_\_ No \_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your medical insurance cover any therapy for autism? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe coverage or attached a description provide by your insurance company: \_\_\_\_\_  
\_\_\_\_\_



**NOTE:** To be considered for a scholarship award, please also provide a copy of (1) most recent federal 1040 income tax return, (2) most recent W-2 for you and/or your spouse if applicable, and (3) medical diagnosis or IEP if available. Incomplete or missing requested information will influence award eligibility.

If you need assistance or have any questions, please email the HALO Scholarship Committee at: [info@halodance4autism.org](mailto:info@halodance4autism.org)

The financial information provided by the applicant shall be used for the sole purpose of determining scholarship eligibility and will be retained by HALO in strict confidence and will not be shared or used for any other purposes. Once the scholarships have been awarded, all financial information provided shall be destroyed.

Please be advised that HALO has no responsibility or obligation to notify any governmental healthcare agencies or entities of the awarding of any scholarship monies. Those responsibilities, if any, are assumed to be held by the scholarship recipient.

I certify that all the information provided is truthful and a full accurate statement of my household's financial situation. If it is later discovered that material misstatements have been made, you will be required to reimburse HALO for the scholarship moneys. I understand that I will be expected to pay a portion of the services or program and HALO maximum payment is limited to the scholarship award granted. I understand that HALO reserves the right to refuse assistance to any applicant.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name

**FOR OFFICE USE ONLY:**

Award Amount \_\_\_\_\_ Program \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

Director Initials: \_\_\_\_\_ Date \_\_\_\_\_