SCHOLARSHIP GUIDELINES AND PROCEDURES

Application deadline: May 29, 2023

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 as- sistance and financial contributions.

Our Scholarship Program for 2023 is through an application process that will be distributed throughout Orange County, California 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 2023 will range between $1,000-$4,000 per family and the student must live in Orange County, California 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, 2023.

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. Servic- es 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 pro- fessionals. 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, form 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 suc- cess 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.

Email applications to: **HALO Foundation/ Amanda Cathey amanda@halodance4autism.org**

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

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FINANCIAL AID SCHOLARSHIP APPLICATION

2023 Applications must be received by May 29, 2023

_____ _____ Male_____ Female_____
Name of Applicant who will benefit from this scholarship Date of Birth

_____
_____ 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.

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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 $_____

TOTAL MONTHLY INCOME $_____

MONTHLY EXPENSES

Rent or Mortgage $_____

Utilities $_____

Food $_____

Clothing $_____

Car Expenses (gas, insurance, loan, etc) $_____

Other Transportation Expenses $_____

Medical Insurance $_____

Medical Expenses $_____

Other Expenses $_____

TOTAL MONTHLY EXPENSES $_____

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:

_____

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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:

_____

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Is your child eligible to receive financial aid from any other agency Yes ____ No____

If yes, please provide the name and agency and the amount being received.

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Please describe how you think this scholarship will benefit you, or any other information that will help us evaluate your appli- cation such as impact on your child, financial situation not listed above, or your child's special needs. Attach additional pages as necessary.

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NOTE: To be considered for a scholarship award, please also provide a copy of (1) most recent federal 1040 income tax re- turn, (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: HaloDanceCharity@gmail.com.

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 scholar- ships 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

_____

_____

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Director Initials: _____ Date_____