HWH - Heroes With Handicaps, Inc.

Financial Request Application

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Child's Name/ Age/ & Date of Birth   Parents

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Address   Phone #   Email

Autism Requirement:

Has your child been diagnosed with Autism? ____________ List other diagnosis/es ____

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Military Requirement:

Is one of the parents on Active Duty or Retired from the US Military? _____________Branch & Rank ___________________________

Insurance:

Health Insurance Provider ____Phone # ________________________________

State & Federal Programs:

Does your child receive any State Assistance? _________ If Yes, please explain ____

____ ____________________________

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Does your child receive any Federal Assistance? ________ If Yes, please explain ____

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School District:

Name & Phone # of Local School District ____

Does your child receive services from the local School District? _____________ Please explain __________________________________

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Have you filed for Due Process against the school district for service issues? __________ If Yes, please explain ___________________

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Autism Services/Treatments:

What services/treatments are you requesting assistance for?____

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Did a Physician prescribe this service/treatment for your child**?** _______________ If Yes, please include letter/prescription with application

Do you receive any assistance (financial or otherwise) for the services/treatments that you are requesting? ________________________

If Yes, please explain in detail ____

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*****IMPORTANT***: In order to receive financial assistance from HWH, you must exhaust ALL sources of public assistance first**

(this includes Tricare, other Insurance, State Programs, Federal Programs, School Districts, etc) ***

APPLICATION SUMMARY: PLEASE DESCRIBE IN DETAIL WHAT IS BEING REQUESTED AND WHY. Be very specific, using additional paper if necessary. Please include information about any financial hardships or extenuating circumstances you would like considered. Please describe how you have exhausted all available forms of public assistance (see above paragraph). Please send copies of all relevant documentation pertaining to this application (Diagnosis from a Physician, School IEP/notes, School district letter of non-availability, Insurance Denials, Provider receipts/invoices, State/Federal denials, PCS Orders or DD-214)

*****All information submitted to HWH shall remain confidential. Please note that, pursuant to federal law requirements, HWH reserves the right to follow up to ensure any approved assistance was actually used for its intended purpose.**

I certify that the information on this form is true and complete to the best of my knowledge.

Applicant Signature **Date**

Please send this application, all supporting documentation, & the Liability Release to:
Heroes With Handicaps, Inc.
22519 Country Cove Ln
Katy, TX 77494

Heroes With Handicaps

Liability Release

By signing this liability release, I/we____

certify that I/we are requesting assistance from Heroes With Handicaps.

I/we hereby release and save harmless Heroes With Handicaps and any and all of its board members, directors, volunteers, and affiliations from any and all liability, claims, causes of action or damages arising out of any injury, illness, or loss of any kind, known or unknown, to my child and family as a result of any treatment or referral provided or assisted by Heroes With Handicaps.

Parent Signature _____________________________________Date________

Printed Name____

Parent Signature _____________________________________Date________

Printed Name____

Child's Name ____