Carle Auditory Oral School

Funding Source Identification and Request Form
Updated April 2014

Child's Name: _____ Date of Birth: _____

Section 1: Family Financial Information

A. Please attach a copy of your most recent income tax forms (unless fully funded by school district). If you do not have a tax form from last year, you must submit proof of income. Please see director for acceptable forms.

B. **Net Income: _____ (Taxable income)** On Form 1040, you will find this number on Line 43. On Form 1040A, you will find this number on Line 27.

C. **Explanation of Special Considerations**: Please share additional information about your financial responsibilities that you would like us to consider in determining your financial need. Examples include: transportation costs, vehicles and food as well as other payments (e.g., school tuitions, child support…) that impact your family's ability to fund your child's education. Please include the amount you feel your family could pay to access the support provided at CAOS. Attach an additional sheet if necessary.

_____

_____

_____

How much money would your family be able to commit to your child's communication skill development each month? _____

D. Insurance Information:

1. **Primary Insurance Company**: _____

Member Name: _____ Member Birth Date: _____

Policy Number: _____ Group Name/Number: _____

Plan Year: Jan/Dec Jul/Jun Other: _____

Insurance coverage for therapy? # of sessions covered per plan year: _____ or dollar amount maximum: _____

What therapy services does this include? (Please circle covered services)
Speech Occupational Therapy Physical Therapy Other: _____

What other specialty services will your child receive in the coming year?

_____

Plan Pays _____ % Family responsible for _____% or $_____ co-pay.

2. **Secondary Insurance:**_____

Member Name: _____ Member Birth Date: _____

Policy Number: _____ Group Name/Number: _____

Plan Year: Jan/Dec Jul/Jun Other: _____

Insurance coverage for therapy? # of sessions covered per plan year: _____ or dollar amount maximum: _____

What therapy services does this include? (Please circle covered services)
Speech Occupational Therapy Physical Therapy Other: _____

What other specialty services will your child receive in the coming year?

_____

Plan Pays _____ % Family responsible for _____% or $_____ co-pay.

E. Funding Already Requested/Explored: YES/ NO Outcome

Alexander Graham Bell Association for the Deaf and Hard of Hearing* _____ _____
Service Clubs: Lions Club (www.lionsclubs.org) _____ _____
Sertoma (www.sertoma.org) _____ _____
Kiwanis (www.kiwanis.org) _____ _____
*(www.agbellil.org)
Others:
_____ _____ _____
_____ _____ _____

F. School District Information (3 – 6 Year Olds)

Name of School District: _____

Director of Special Education (or equivalent): _____

Address: _____ City _____ State ____ Zip _____

Phone: _____ Fax: _____

E-mail: _____

Explain the Steps You Have Taken To Secure School District Funding: _____

_____

_____

List Specifics of Contract (if applicable): _____

_____

Section 2: Narrative

The purpose of this section is to ensure that the family's commitment to developing listening and spoken language skills warrants financial support from The Carle Development Foundation. Producing successful listening and spoken language communicators is the goal of CAOS and the Carle Development Foundation. That goal cannot be achieved without support and commitment from home. Ensuring that there is family support and commitment is essential before awarding financial support.

Why do you want your child to attend Carle Auditory Oral School? _____

_____

Why do you want your child to develop listening and speaking skills? _____

_____

_____

Why are you requesting financial aid / scholarship? _____

_____

_____

Section 3: Expectations:

What will your child be doing at each of these time slots with the auditory oral communication skills they develop in this program? Possible examples include: saying "mama", "talking in sentences", "working on the phone as a telemarketer", "going to school with hearing peers", "attending a university of their choosing"… There are many possibilities. What are your goals for your child?

In 6months:_____

At Age 6: _____

At Age 10: _____

At Age 18: _____

At Age 25: _____

Research shows that children with involved families progress farther and more rapidly. Please initial below to indicate your willingness to do each of the following to help maximize your child's progress at Carle Auditory Oral School.

_____ Provide transportation to and from Carle Auditory Oral School

_____ Ensure a timely arrival for school and therapy sessions

_____ Secure funding for / Make family sacrifices to pay my child's tuition

_____ Participate in fundraising activities for the school

_____ Participate in education opportunities

_____ Complete daily journal entries for class and therapy, as needed

_____ Check folder regularly / respond to communication from CAOS

_____ Read to my child nightly

_____ Participate in Parent-Professional collaboration meetings

_____ Share information with school about your child's use of targets when not at school.

_____ Enforce amplification during all waking hours

_____ Continue to "up the ante" regarding my child's use and understanding of acceptable communication and spoken language.

_____ Participate in up to three Parent Teacher conferences during the school year.

I/ We certify that the above information is true to the best of my/our knowledge.

_____ Date _____

_____ Date _____

Thank you for taking the time to complete this application. The information included in this application will provide the funding committee with the information necessary to ensure that families receive needed financial assistance and that the funds being accessed are being used responsibly.