Great River Autism Connection
BOOST Application

Quincy Medical Group Foundation GRAC BOOST grants up to **$1,000** per person and is designed to provide access to equipment, materials, and/or tools that enhance and improve the quality of life for individuals with a current Autism Spectrum Disorder diagnosis. Payments will be made directly to vendors OR come in the form of a gift card.

The Foundation will assist with needs related to:

- Communication
- Activities of daily living
- Instrumental activities of daily living
- Motor skills
- Mobility
- Social skills
- Adaptive equipment
- Transportation
- Equipment
- Sensory processing
- Education
- Safety
- Nutrition

The Foundation is unable to assist with needs such as:

- Medical or insurance bills
- Cable bills
- Long-term or forward payment past 2-3 months
- Outstanding loans or bad debt *(including bills that have sent to collections, involved in any court processes or fees, etc.)*

Please obtain these required documents and have them ready before you begin the application. You will need to upload them to your application.

- Proof of autism diagnosis. Please provide a copy of a formal report, medical documentation, Individualized Educational Program (IEP) report or completed Confirmation of Diagnosis form, found on page 4 of this application.
- Proof of cost for the equipment, materials, and/or tools.

You may also provide additional documentation or paperwork that would aid in the decision making and help tell the story of how this request will benefit your child.

GRAC Boost Request

Parent/Legal Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Child Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Autism Diagnosis: _____

Primary Care Provider: _____

Please list therapies/services individual currently receives: _____

Are you currently on a waitlist or seeking additional therapies or service? Y N

If so, please list: _____

Are you seeking other financial resources? Y N

Have you received any financial assistance in the past 12 months? Y N

If so, where/amount? _____

Please attach these **required** documents:

☐ Proof of autism diagnosis

☐ Proof of cost for equipment, materials, and/or tool.

☐ Summary of Request:

In 250 words or less, tell us about your child, what you are applying for, and explain how funding this request will help your child.

☐ Any additional documentation you feel will aid in the decision making and help tell the story of how this request will benefit your child. *(not required)*

The committee reserves the right to request additional information to aid in their final decision.

☐ *My signature below attests that the above information is accurate.*

_____ _____

Parent/Legal Guardian Signature Date

Request for Open Communication

QMG Foundation is committed to patient privacy. Information is released according to our Notice of Privacy Practices. This release only allows verbal communication. Written documentation will not be given out. In order for staff to speak with those you designate, this written permission form should be completed and returned to any staff member. Protected Health Information (PHI) must be specifically identified for release.

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

By providing your signature, you indicate your consent to open communication with vendors and the QMG Foundation team. Please list the names of any personal relationships that would be allowed to discuss your Boost Request with the QMG Foundation team.

Name	Relationship to you	Phone Number
Name	Relationship to you	Phone Number
Name	Relationship to you	Phone Number

This authorization expires once Applicant's Boost Request has been granted by the Quincy Medical Group Foundation or a final determination has been made that the Applicant is not eligible to receive a Boost Request.

If at any time I wish to revoke this request, I must notify the QMG Foundation in writing. I understand that I can receive a copy of this form for my records if requested.

Signature of Patient or Legal Representative	Date

Confirmation of Diagnosis

Child's Name: _____DOB: _____

Primary Care Physician: _____

Parent /Guardian Name: _____

Mailing address: _____
(Apt, number, street)

_____
(city/town/village) (zip code)

Telephone: _____

Parent/Guardian Signature: _____

Parental or guardian signature indicates agreement with the information provided and gives consent to be contacted by a Quincy Medical Group Foundation Great River Autism Connection committee member regarding services and gives permission for the diagnosing professional to disclose Confirmation of Diagnosis and diagnostic write-up to the Quincy Medical Group Foundation.

<u>This Part to Be Completed by Diagnosing Professional Only</u>

Profession: ☐ Physician: _____
(specialty)
☐ Psychologist
☐ Psychiatrist
☐ School Psychologist

Name: _____

Address: _____

Phone Number: _____

Diagnosis: ☐ Autism Spectrum Disorder (ASD)

Diagnostic Assessment Tools used:

_____

_____

_____

☐ Form completed by office staff on behalf of diagnosing professional.

_____ _____
Name (please print) Date

_____ _____
Signature Date