

# Autism Evansville (AE) Voucher Program Policy

## Charter / Purpose:

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The purpose of the Voucher Program is to provide a lump-sum amount to selected (awarded) recipients to assist with paying for autism-related products or services.

## Scope:

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The program is designed to provide a financial voucher award paid to the provider of autism-related products or services identified by the award recipient.

## Program:

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1. Autism Evansville will promote this program through the Autism Evansville website, Facebook page, and via email when possible.
2. Applicants shall complete in full an Autism Evansville Voucher Program application, and shall agree to the terms and conditions of this policy.
3. The signed policy and completed application shall be postmarked by December 15, 2018. Applicants may either send their completed applications via US Mail (to Autism Evansville, PO Box 8052, Evansville, IN 47716), or turn in completed applications to their selected service provider, who will submit the application to Autism Evansville. Applications received via email will not be considered. There will be no exceptions for late applications, or for incomplete applications. Any applications received by Autism Evansville after the deadline, whether by mail or from a service provider, will not be considered.
4. The awarded recipient(s) will be notified by the Program Monitor that they have been selected to receive the voucher award. Applicants who did not receive the award will not be contacted.
5. Voucher awards shall be awarded to the selected recipient and shall be paid directly to their provider of choice (on behalf of the recipient) to receive products or services from the provider.
6. Once a recipient has received a voucher award, he/she is unable to reapply for another voucher award for a period of 12 months from the date of the award.
7. A recipient is required to utilize the funds awarded to the provider within 12 months of receiving the award. Any unused funds remaining after the 12-months has passed shall be forfeited.
8. Providers must agree to the terms and conditions of receiving and applying voucher award funds. Autism Evansville may request the return of unused funds from the provider at the end of 12 months. Providers and recipients are required to sign a Provider Agreement form prior to commencement of services and payment.
9. There can be no voucher payment for a service or product that has been received or purchased prior to the date that the voucher was awarded, or the date that the Voucher Provider Agreement form has been signed by the provider and recipient.
10. If the voucher award is for the purchase of a product, the cost of the product must be equal to or less than the amount of the voucher award, including tax and shipping costs.
11. Voucher recipients will be requested to complete Autism Evansville survey questions and follow-up inquiries about the program.
12. If a recipient is released from the service for which the voucher was awarded before the full amount of the voucher has been spent, or voluntarily leaves the chosen provider of services, there can be no transfer of the remaining voucher amount to another family, individual, provider of services, or to the same provider for a different service.

13. If a recipient is released from the service for which the voucher was awarded before any of the voucher amount has been spent, there can be no transfer of the full or partial voucher amount to another family, individual, provider of services, or to the same provider for a different service. In this case only, the recipient will be eligible to reapply for the voucher program the next time it is offered.

**Selection Process:**

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1. All completed applications will be reviewed by a designated Program Monitor. The Program Monitor will complete a summary of each application so that all identifying information is concealed. Each application summary will be assigned an identification number.
2. The Selection Committee will review the application summaries to determine the Autism Evansville voucher award(s) for that selection period.
3. Members of the Autism Evansville Board (and their households) shall be excluded from eligibility of the Autism Evansville Voucher Program.
4. To be eligible for consideration, the applicant must meet eligibility requirements (the individual for whom the voucher is intended is a legal dependent age 21 or under with an autism diagnosis, he or she lives within the counties Autism Evansville serves [Posey, Vanderburgh, Warrick, Spencer, Gibson, Pike], and the applicant completes in full an Autism Evansville Voucher application, including this signed policy).
5. Preference may be given to situations where the individual is not waitlisted for the requested services.
6. Thereafter, the Criterion used for consideration will include, but not be limited to:
  - a. The description of the needs identified by the recipient
  - b. The proposed products/services identified by the recipient
  - c. The cost of the products/services that will be received
  - d. The financial hardship of the recipient

Autism Evansville makes no representations, warranties or opinions regarding the effectiveness or appropriateness of services or products funded on a designated award recipient's behalf via Autism Evansville's Voucher Program. Payment of voucher awards to service or product providers (hereinafter collectively referred to as "providers") on a designated recipient's behalf are contingent upon the provider's ability to coordinate payments in conformity with Autism Evansville's Voucher Program procedures as determined by Autism Evansville in its sole authority and discretion. Autism Evansville reserves the right to revoke its award to a designated award recipient at any time prior to the actual payment of the award to a provider, and designation of an award recipient does not guarantee that Autism Evansville will be able to coordinate payment with the recipient's identified provider. In the event that payment cannot be coordinated with a designated recipient's identified provider, Autism Evansville may in its sole authority and discretion revoke the voucher award, or Autism Evansville may request the designated award recipient identify an alternative provider. Any voucher award that has not started payment to a provider on behalf of a designated recipient within 60 days of the recipient's designation date is subject to revocation by Autism Evansville in its sole authority and discretion.

I agree to the terms and conditions of the Autism Evansville Voucher Program Policy.

Please sign \_\_\_\_\_ Date \_\_\_\_\_

Name (please print) \_\_\_\_\_

# Voucher Application



## Autism Evansville Use Only

PO Box 8052 Evansville, IN 47716

Application Code: \_\_\_\_\_

P: 812-202-9405

Award Date: \_\_\_\_\_

This program is designed to provide a financial voucher award payable to the provider of a service related to autism on behalf of the award recipient. The voucher award will not be paid to the recipient directly. This application must be filled out completely and accurately for consideration. All information will be kept confidential.

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Individual's Last Name	Individual's First Name	M.I.
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Individual's Date of Birth	Individual's Age	M/F
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Parent/Guardian's Last Name	Parent/Guardian's First Name	M.I.
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Address: Street	City/State	Zip Code
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Preferred Phone Number	Email
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1. Has the individual received a Voucher Award in the past? If so, what month/year?  
\_\_\_\_\_

2. Approximate month/year individual was diagnosed with autism spectrum disorder:  
\_\_\_\_\_

Who diagnosed the individual with autism spectrum disorder? \_\_\_\_\_

3. Family size (supported by stated income below): \_\_\_\_\_

4. Adjusted Gross Income (circle one):                      \$29,999 or less      \$30,000 – 49,999      \$50,000 – 69,999

Note: Applicants will not be deemed ineligible      \$70,000 – 99,999      \$100,000 or more

based on income alone.

5. Please list the individual's primary, secondary & supplemental health insurance if applicable (including Medicaid) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the individual on the "Autism Waiver" (Medicaid Family Supports Waiver)? YES \_\_\_\_\_ NO \_\_\_\_\_

Please complete next page

6. Please list all services and therapies currently received by the individual (ABA, Speech Therapy, etc.)  
**DO NOT INCLUDE SERVICES RECEIVED AT SCHOOL**

7. What type of service will the Autism Evansville voucher cover for the individual, if awarded?

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8. Please describe how autism impacts the individual and your family. Please continue on back or attach more pages if needed.

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9. Please choose ONE service provider for your voucher award. *Note: contact your chosen service provider in advance to make sure the individual's needs can be accommodated. Vouchers will not be awarded to families who have not contacted the provider.*

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| <input type="checkbox"/> SPOT Services                               | <input type="checkbox"/> Easterseals Rehabilitation Center                |
| <input type="checkbox"/> Assistive Technology Solutions              | <input type="checkbox"/> BrainPower Neurodevelopmental Center             |
| <input type="checkbox"/> Integrative Music Therapy                   | <input type="checkbox"/> Optimal Rhythms/ACCESS Academy                   |
| <input type="checkbox"/> Forefront Therapy, LLC (OT and PT services) | <input type="checkbox"/> Harsha Autism Center (ABA)                       |
| <input type="checkbox"/> HopeBridge Evansville Clinic (ABA)          | <input type="checkbox"/> Brian Carroll (legal counsel for guardianship)   |
| <input type="checkbox"/> Ambucs (therapeutic bicycles)               | <input type="checkbox"/> Optimum Wellness Pharmacy (compounding pharmacy) |
| <input type="checkbox"/> LittleStar ABA Therapy                      |   |

**PLEASE DO NOT WRITE IN ANY OTHER PROVIDERS**

10. Who have you spoken to at the above chosen organization about this voucher application?

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By signing this form, the applicant represents that all information provided is truthful and accurate. The applicant certifies that the individual specified has received a diagnosis of an autism spectrum disorder from a qualified professional. The applicant also recognizes AE reserves the right to request verification of any information on the application. Furthermore, the applicant acknowledges that they have read and understand the AE Voucher Program Guidelines and agrees to comply with all requirements of this program. The applicant holds no liability to AE or its members for this program or for the quality of provider services received.

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Applicant Signature

Autism Evansville, PO Box 8052, Evansville, IN 47716 812-202-9405

Date

Revised 10/20/18