Aging and Disabilities Services Division
Autism Treatment Assistance Program

Financial Disclosure Form

(Child's First, Last Name) (Date)

The Autism Treatment Assistance Program (ATAP) uses your monthly gross income to qualify you for financial help. The program must check this each year.

Please fill out this form with your monthly gross income so ATAP can check if your family can get the most support possible.

How much money does your household make each month before taxes (gross income)?

(Gross Monthly Income)

How many people in your household are supported by this income?

(Number of People)

Do you have proof of out-of-pocket medical costs for anyone in your household? Proof can be receipts, or medical statements that show payments were made. These costs must be from the same year as your tax return.

☐ Yes ☐ No

ATAP will use the out-of-pocket medical costs to reduce your gross monthly income. This reduction is used to decide your funding level.

Return this form with proof of income, like your federal tax return or most recent pay stubs.

☐ I agree that the information on this form is accurate and true.

☐ I agree to provide this information each year and at the request of the program.

(Parent/Guardian First, Last Name)

(Parent/Guardian Signature) (Signature Date)

Clear Form