

EMPOWERED KAT6 FOUNDATION

Please read the following before completing the application.

Applications are accepted on a rolling basis starting **January 1** and are reviewed in the order received.

Frequently Asked Questions

Do I need to live in the U.S. to apply?

No. We welcome international applicants.

Is there an application deadline?

No. Applications are accepted until the annual grant budget is exhausted.

What does the Empowered Grant provide?

Funding for assistive equipment/technology or private therapies, such as:

- iPads, AAC software/apps
- Gait trainers, adaptive switches
- Weighted blankets, glasses, feeding tools
- Therapeutic swings

Eligible therapies:

- Speech, OT, PT, ABA, feeding, vision, hearing
- Hippotherapy, aquatic, music/art therapy, pet therapy

Maximum grant: \$600 USD, limited to one grant per individual per year for up to two consecutive years.

Eligibility Requirements

1. Confirmed diagnosis of KAT6A or KAT6B mutation
 - *Attach genetics report*
 2. Developmental delays requiring assistive equipment or therapy
 - *Attach proof (IEP, PCP report, neuropsych evaluation, etc.)*
 3. Applicant's parent/guardian must not be on the KAT6 Foundation Board
- One application per year per individual

How are funds distributed?

- **U.S.:** Check or PayPal
 - **International:** PayPal or wire transfer
- Receipts from the same calendar year must be submitted to receive reimbursement*

Need help? Email: KAT6Aempowered@gmail.com

Request over \$600? Email: support@kat6a.org if you need special assistance for a larger grant.

Application Checklist – Required Attachments

- Genetics report confirming KAT6A or KAT6B variant
- Documentation of developmental delay (IEP, PCP, therapy report, etc.)



Empowered Grant Application Form

Section 1: Personal Information

- Full Name of KAT6 Patient: _____
- Date of Birth: _____
- Address: _____

- Email: _____
- Phone Number: _____
- Parent/Guardian Name: _____

Section 2: Grant Request Details

Describe the item, therapy, or app requested and its intended purpose. Include name/model for equipment, or provider contact for therapies.

Equipment Price: \$ _____ OR Therapy Cost: \$ _____

Have you received an empowered grant in the past? _____

Section 3: Provider Information

- Diagnosing Doctor's Name: _____
- Doctor's Phone/Email: _____
- Current Therapist/Specialist: _____
- Therapist's Phone/Email: _____

Section 4: Agreement

By signing below, I confirm:

- Medical insurance does **not** cover the requested item or therapy
- School district does **not** cover the requested item or therapy
- All information provided is accurate
- I authorize KAT6 Foundation to contact listed providers
- I understand falsified info leads to disqualification
- I acknowledge the reimbursement limit of **\$600 USD**

Signature (Parent/Guardian): _____

Date: _____

NOTE:

Applications will **not** be reviewed without:

- ✓ All required documentation
- ✓ Completed application form
- ✓ Signature

All information is confidential and used only by the KAT6 Foundation.

Submit completed applications and documents to:

 KAT6Aempowered@gmail.com