

Autism Help Network, Inc.  
Grant Application

Today's Date: \_\_\_\_\_

How did you hear about Autism Help Network? (If referred, please list the name of the person or organization.)

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Identifying Information

Applicant (Child affected with ASD):

\_\_\_\_\_  
Name Date of Birth

\_\_\_\_\_  
Current Age Gender Date Diagnosed

Guardian(s):

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Telephone Number Alternate Telephone Number

\_\_\_\_\_  
E-Mail Address

Dependent(s)/Sibling(s)[excluding applicant]:

\_\_\_\_\_  
Name Age Relationship

\_\_\_\_\_  
Name Age Relationship

\_\_\_\_\_

## History

\_\_\_\_\_  
Current Diagnosis

\_\_\_\_\_  
Diagnosed by (Name of Physician/Psychologist/Psychiatrist)

\_\_\_\_\_  
Name of Institution/Agency

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Type of Treatment	History (Circle one)	Frequency	Provider
Speech Therapy	Current/Past		
Occupational Therapy	Current/Past		
Physical Therapy	Current/Past		
Applied Behavior Analysis	Current/Past		
Special Diets	Current/Past		
Biomedical Testing	Current/Past		
Biomedical Interventions	Current/Past		
Social Skills Group	Current/Past		

Please list below any other information pertaining to treatment. Attach another sheet of paper if additional space is needed.

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the Autism Help Network grant review process. I give Autism Help Network permission to verify treatment information by contacting treatment providers directly. This authorization shall be valid for one year, unless otherwise stated. I understand that I may revoke this authorization in writing at any time. (\*Please be sure to sign a release of confidential information with your treatment provider.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Funding Request

Type of Grant: Scholarship/Schooling

Treatment/Therapy

Biomedical/Medical

Describe how the funding will be used:

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\*Please include supporting documentation (i.e.; invoices or receipts from current service providers and/or estimates of costs for services).

Financial Information

Guardian #1:

Place of Employment

Gross Monthly Income

Street Address

Work Phone

City

State

Zip Code

Guardian #2:

Place of Employment

Gross Monthly Income

Street Address

Work Phone

City

State

Zip Code

Other sources of income:

Source

Gross Monthly Income

Source

Gross Monthly Income

Source

Gross Monthly Income

\*Note: If currently unemployed, please provide proof of unemployment benefits (if applicable); otherwise, provide proof that no income is present at the current date.



## Required Documents

1. Copy of Psychological Evaluation or medical report verifying ASD diagnosis
  - a. Must include physician's/psychologist's/psychiatrist's signature
  - b. Examples of acceptable documentation include, but are not limited to, Psychological evaluation, formal letter from pediatrician/physician, etc.
  - c. Inform your physician that diagnosis must be consistent with the Diagnostic and Statistical Manual (DSM – IV – TR)
2. Any invoices/receipts of accounts to which grant will be payable
  - a. Invoices/receipts from current services
  - b. Estimates of costs for future services (i.e., school)
3. Income Verification
  - a. Most current pay stubs, 1099, SSI award letters, etc.
4. Copy of 2008/2009 Tax Return
  - a. Please note if you have not filed a 2009 Tax Return and the reason you have not done so
5. Any additional information that you deem relevant or can verify special circumstances

## Disclaimer

Only complete applications will be accepted. If you are approved for a grant, you will be notified by mail. We do not accept phone or email inquiries regarding the status of your application. Incomplete applications will be returned.