

2007 GRANT APPLICATION NATIONAL AUTISM ASSOCIATION - NORTHEAST OHIO (NAA-NEO) HELPING HAND PROGRAM

The NAA-NEO Helping Hand Program provides families with financial assistance in getting respite care, a variety of therapy services (i.e. speech therapy, occupational therapy, tuition assistance, marriage counseling for parents, and others), as well as necessary medical testing and treatments, including biomedical treatments for their dependent(s), child, or children with autism. For a full list of eligible requests please go to our website at www.autismnortheastohio.org or contact Andrea Pattison at apattison@autismnortheastohio.org.

Please completely review the following information.

Applications must be postmarked by October 31, 2007 to be considered for our 2007 Helping Hand Program.
Applications postmarked after October 31, 2007 will be evaluated in our spring review process.

**Please mail applications to:
NATIONAL AUTISM ASSOCIATION - NORTHEAST OHIO Chapter
Attention: HELPING HAND PROGRAM
PO Box 221195
Beachwood, Ohio 44122**

Frequently Asked Questions

This program is intended for families in great financial need with a child/dependent who has been diagnosed with autism.

Q: How do I know if my child/dependent qualifies for help from the National Autism Association?

A: Your child/dependent must meet these basic criteria:

1. Reside in Cuyahoga, Lake, Geauga, Lorain, Summit, Medina, and Portage counties of Ohio.
2. Diagnosed with an autism spectrum disorder.

There is no upper age limit for your child/dependent to receive funds from this program.

Q: How much money can I request?

A: The maximum amount we can award per family is a one-time grant of One Thousand Dollars (\$1,000).

Q: Can I apply for a grant in the amount of One Thousand Dollars (\$1,000) for each eligible dependent?

A: You can fill out a separate application for each eligible child/dependent. Depending on the volume of applications received NAA-NEO may or may not be able to consider more than one application per family.

Q: How do I apply for assistance from the National Autism Association for my child/dependent?

A: First, review the basic criteria above. If you meet these, complete a GRANT APPLICATION. You must attach a letter from your child's/dependent's physician that confirms your child's/dependent's diagnosis. If your request exceeds Three Hundred Dollars (\$300), you must provide a copy of your most recent tax return.

Q: Are grant funds paid directly to families?

A: At no time are funds transferred to families. All grants awarded are paid directly to the vendor or service provider to pay for services.

Q: I've sent my application in. How long until I know if my application has been approved?

A: Once we have received all components of the application (completed application form, doctor's letter and tax returns, if applicable, and all necessary documents), your application will be reviewed by NAA-NEO within four (4) weeks. **ONLY APPROVED GRANT RECIPIENTS WILL BE CONTACTED BY NAA-NEO.** Grants will be disbursed by the end of the year 2007.

Q: I have health insurance. Can I still apply for assistance?

A: Yes. However, we encourage you to explore your health insurance coverage to the maximum extent so that we can help with those expenses that cannot be covered by any other source.

Q: We have so many medical bills, we're having trouble paying the rent/electric/water/telephone bills. Can NAA-NEO help us?

A: The guidelines of this grant do not allow payment for anything other than respite care, a variety of therapy services (i.e. speech therapy, occupational therapy, tuition assistance, marriage counseling for parents, and others), as well as necessary medical testing and treatments, including biomedical treatments for their dependent(s), child, or children with autism. For a full list of eligible requests please go to our website at www.autismnortheastohio.org or contact Andrea Pattison at apattison@autismnortheastohio.org.

APPLICATION FORM

The information you provide in this application form is confidential. It will be reviewed by NAA-NEO Board Members only and used for determining your family's eligibility to receive funding through the Helping Hand Program. As this grant program is based on financial need, it is necessary for us to have a complete application form returned so that we can best determine which families are in the greatest need of funding. Further, NAA-NEO does not endorse any of the interventions or therapies for which we provide funding. We believe that it is the family's right to decide what treatment options to pursue for their child/dependent in collaboration with a team of medical and educational professionals.

1. INFORMATION ABOUT THE CHILD (children) or older DEPENDENT(s) in need of funding for autism related therapies, respite, etc.

Child/Dependent Name: _____

Age: _____ Date of Birth: _____

Medical Diagnosis Or Disability/Disabilities: _____

Please tell us more about your child/dependent, his or her needs and challenges: _____

2. OTHER DEPENDENT CHILDREN/DEPENDENTS:

Number of other dependent children: _____ Ages: _____

Number of other dependents: _____ Ages: _____

3. OTHER DEPENDENT CHILDREN/DEPENDENTS WITH ASD OR OTHER DISABILITIES:

In case you have more than one child/dependent diagnosed with autism spectrum disorders, or any other disabilities, please tell us about them also. Leave this area blank if you do not have other children and/or dependents.

Other Child/Dependent Name: _____

Age: _____ Date of Birth: _____

Medical Diagnosis Or Disability/Disabilities: _____

Please tell us more about your child/dependent, his or her needs and challenges: _____

Other Child/Dependent Name: _____

Age: _____ Date of Birth: _____

Medical Diagnosis Or Disability/Disabilities: _____

Please tell us more about your child/dependent, his or her needs and challenges: _____

(Please attach additional pages as necessary).

4. Information about the Mother

Mother's Name: _____

Marital Status: _____ Telephone: _____

Address - Street/City/Zip: _____

Employer: _____ Telephone: _____

Employer Address: _____

10. PERSONAL STATEMENT OF INCOME AND FINANCIAL STATUS OF CUSTODIAL PARENTS OR GUARDIANS

ASSETS

Checking account \$ _____
Savings account \$ _____
Home value \$ _____
Other real estate \$ _____
Automobile value \$ _____
Personal property values \$ _____
Other assets \$ _____
Total assets \$ _____

Family's Monthly Budget

FAMILY'S MONTHLY AVERAGE LIABILITIES

- Monthly House Payment/Rent: \$ _____
- Monthly Utilities: \$ _____
- Monthly Insurance (total for car, medical, life, dental, other): \$ _____
- Monthly transportation costs (car payment, lease, gas, public transportation): \$ _____
- Average monthly grocery bill (include cleaning supplies, personal health care products, GFCE or other dietary costs): \$ _____
- Monthly pharmaceutical average (including medications, supplements not covered by another source such as prescription coverage, co-payments): \$ _____
- Monthly medical average (including doctors' co-payments, fees not covered by health insurance or other source): \$ _____
- Monthly therapy costs not covered my health insurance or other party (including speech, occupational, physical therapy fees and/or co-pays): \$ _____
- Average monthly costs of other autism related expenses such as interventions not included above, (i. e. tuition expenses at private autism schools, summer camp costs, equipment, special toys, adaptive devices, etc.): \$ _____
- Average monthly expenditures on clothing, etc. \$ _____
- Respite, child/dependent care: \$ _____
- Other (please specify bills, student loans, other types of loans and payments, etc.): \$ _____

Total monthly liabilities: \$ _____

FAMILY'S MONTHLY AVERAGE INCOME

- Salaries: \$ _____
- Bonuses and commissions: \$ _____
- Real estate income: \$ _____
- Social Security Benefits: \$ _____
- Alimony/Child Support: \$ _____
- Grants: \$ _____
- Medicaid: \$ _____
- WIC: \$ _____
- Food stamps: \$ _____
- Other income (please specify): \$ _____

Total monthly income: \$ _____

11. Would you be able to provide the therapy/intervention for your child/dependent without the NAA-NEO Helping Hand Program? Please circle the answer that fits your family's situation best.

Yes

No

Yes, but with difficulty

Please attach:

1. Combined sources of income:

Previous year's IRS return (1040) must be attached if grant request is above \$300.00.

2. Doctor's Letter:

We must have a letter from your child's/dependent's physician which states the child's/dependent's diagnosis and confirms your request is necessary or beneficial for your child/dependent.

3. Doctor's/therapist's/other professional's letter:

We must have a letter from the professional recommending the therapy/treatment/intervention described in this grant request form. i.e., this could be the child's/dependent's occupational therapist, speech therapist, doctor, or music therapist.

Please sign the statement below.

I, _____ (name), hereby confirm that the above information is freely given to expedite this grant request. All of the information provided in this application is correct and can be supported with appropriate documentation upon request by the National Autism Association - Northeast Ohio Chapter (NAA-NEO). I understand that by signing this form I waive my right to hold NAA-NEO responsible for any of the treatments/interventions funded by this program. I understand that it is my right and responsibility to chose treatment/intervention for my child/dependent in collaboration with a team of professionals involved. I understand and agree that I am submitting this information voluntarily and that the Helping Hand Program makes no representations or warranties that money will be dispersed to the applicant and that applicant's application may be denied at the sole discretion of the Helping Hand Program.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

Mail completed application, doctor's letter, and previous year's IRS return (if requesting more than \$300) to:

**NAA-Northeast Ohio
Attention: Helping Hand Program
PO Box 221195, Beachwood, Ohio 44122**

The information included in this application is confidential and for NAA-NEO use only. Please keep a copy for your records. This application cannot be considered until this form is completed, signed, and all supporting documents (including doctor's letter(s) and other professionals' letters supporting this request) are received. Nothing contained in this application should be relied upon as legal or medical advice. The Helping Hand Program disclaims any liability with respect to this application and any consequences resulting from the use of, or reliance on, its contents or any use of the application.