



NATIONAL AUTISM ASSOCIATION - NORTHEAST OHIO (NAA-NEO)

2010 HELPING HAND PROGRAM

GRANT APPLICATION

The NAA-NEO Helping Hand Program provides families with financial assistance in the amount of \$300.00 (three hundred dollars) for respite care, a variety of therapy services (i.e. speech therapy, occupational therapy, behavioral therapy, music therapy, tuition assistance, marriage counseling for parents, and others), camp, as well as necessary medical testing and treatments, including biomedical treatments for their dependent(s), child, or children with autism. If you have a request for a service that does not fall in the above categories, please contact Andrea Pattison at 216.544.1231 or via email at apattison@autismnortheastohio.org.

Please completely review the following information.

Deadline for Applications: May 31, 2010

All applications must be postmarked by May 31, 2010. Applications, if complete, remain active until January 1, 2011. This means that NAA NEO will continue to fund applications waiting as funds become available up to January 1, 2011. **All families both approved in the first round and waiting will be notified via US Postal Mail and e-mail whenever possible by June 30, 2010.** If you do not hear from us by June 30, 2010, your application is likely rejected (you do not qualify) or is missing information. Please feel free to contact Andrea at 216.544.1231 or via email at apattison@autismnortheastohio.org with any questions (e-mail strongly preferred).

Please mail applications to:

**NATIONAL AUTISM ASSOCIATION - NORTHEAST OHIO Chapter
Attention: HELPING HAND PROGRAM
13111 Shaker Boulevard Ste 210
Cleveland, Ohio 44120**

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 – Northeast Ohio (NAA-NEO)?

A: Your child/dependent must:

1. Reside in Ashtabula, Columbiana, Cuyahoga, Erie, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, and Trumbull counties of Ohio.

2. Be 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 child is Three Hundred Dollars (\$300.00).

Q: Can I apply for a grant in the amount of Three Hundred Dollars (\$300.00) for each eligible dependent?

A: Yes, you can fill out a separate application for each eligible child/dependent. However, there is no guarantee that all of the affected children/dependents living in one household will receive a grant. This will depend on the overall demand for our grants this year. 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 and a recommendation letter from a professional for your child/dependent to obtain the service you are requesting financial assistance with (i.e. a doctor may recommend supplements or required testing; an occupational therapist may recommend a weighted blanket). If you need assistance regarding this requirement please contact Andrea Pattison at apattison@autismnortheastohio.org. E-mail is strongly preferred.

Q: Are grant funds paid directly to families?

A: Under some circumstances funds will be paid to families only if the family provides proof of payment for a service that was approved beforehand by NAA-NEO's Board of Directors. NAA-NEO will only reimburse families in two installments/disbursements per year. If a family is approved for a grant, the first deadline to submit receipts and proof of payment for services already paid for by the family is **September 30, 2010**. Families then will receive their reimbursement check from NAA-NEO by **October 30, 2010**. The second and final submission deadline for receipts and proof of payment for services already paid for by families is **January 1, 2011**. Reimbursements to families will be completed by **February 1, 2011**, which concludes the 2010 Helping Hand Grant cycle.

NAA-NEO prefers that NAA-NEO is billed for approved services by the vendor/provider. Funds then are paid directly to these vendors/service providers on behalf of the recipient family within 2-3 weeks of receipt of invoices.

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 and other professional's letter), your application will be reviewed by NAA-NEO by June 20, 2010. NAA-NEO will notify grant recipients via mail and email whenever possible by June 30, 2010. Please make sure you provide your exact current address and that you write it on the form and envelope clearly and legibly. **APPROVED and WAITING GRANT RECIPIENTS WILL BE CONTACTED BY NAA-NEO by June 30, 2010.** "Waiting" application forms remain active until **January 1, 2011**. **We will attempt to fund as many families as possible but on a continuous basis as we obtain funds through our fundraising efforts.**

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 such as speech therapy, occupational therapy, physical therapy, behavioral therapy, tuition assistance, summer camp expenses, marriage counseling for parents or special family counseling, as well as necessary medical testing and treatments, including biomedical treatments for a dependent(s), child, or children with autism. For more information about other eligible services, please contact Andrea Pattison at 216.544.1231 or via email at apattison@autismnortheastohio.org. We strongly prefer contact via e-mail.

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 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 with ASD or other disabilities. **If you are also applying for a grant for these other children/dependents of yours, please fill out a separate application form for them as well as the section below.**

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/Background (i.e. does the mother live with the child/children/dependent(s) affected by autism?

Does the mother support the child/children/dependent(s) affected by autism?

Telephone: _____

Address - Street/City/Zip: _____

Email: _____ Sign up to mailing list: yes ___ no ___ already on the list ___

Employer: _____ Telephone: _____

Employer Address: _____

If not employed, please explain:

5. Information about the Father

Father's Name: _____

Marital Status/Background (i.e. does the father live with the child/children/dependent(s) affected by autism? Does the

father support the child/children/dependent(s) affected by autism?

Telephone: _____

Address - Street/City/Zip: _____

Email: _____ Sign up to mailing list: yes ___ no ___ already on the list ___

Employer: _____ Telephone: _____

Employer Address: _____

If not employed, please explain:

6. Outline of funding requested - One grant per year (per child) maximum - \$300.00 limit

(Please be specific and include all costs) \$

7. Name of other agencies or services also contacted for funding:

Please indicate any and all agencies/organizations that you have contacted for funding and the total amount requested or received (if any), including the Ohio Autism Scholarship Program, county funding from your respective county Board of Developmental Disabilities, P.A.S.S. funding, other public or private funding for tuition, etc. Include if your child/children /dependents have a Medicaid card (Level 1, IO) and the services the waiver provides/covers for your child/children/dependents.

8. 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, GFCF 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. 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.

2. 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, consultant, special education teacher, 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 truthful 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 choose 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 and doctor's/professional's letter to:

**NAA-Northeast Ohio
Attention: Helping Hand Program
13111 Shaker Blvd. Ste 210 Cleveland, OH 44120**

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.