

**AUTISM SUPPORT DAILY'S
Winter 2010
Grant Application**



PLEASE PRINT NEATLY

Requirements:

1. The recipient is the parent or legal guardian of a child or young adult who holds a diagnosis of Pervasive Developmental Disorder /Autism Spectrum Disorder.
2. The applicant and their parent(s) or guardian(s) reside in the state of Vermont.
3. The item/service requested must not otherwise be covered by the family's insurance plan or a state waiver.
4. The parent/legal guardian agrees to provide Autism Support Daily with written feedback as to how the grant helped their family, as well as the receipt or other proof of purchase for the service or product requested, no later than April 1, 2010.
5. This Grant Application has no income limitations. Grants will be paid in this order, *until we have reached our grant budget for this grant cycle*: First to families who have not received a grant from Autism Support Daily in the past *and/or* parents with an annual combined net income of \$75,000 or less. We apologize that we are unable to send letters to those whose grants are not approved. If your grant was approved, your check will be mailed by March 6, 2010. If you do not receive a letter and check from us by March 13, 2010, we were unable to approve your grant application in this cycle and encourage you to apply in our next cycle.

Instructions:

1. Please complete Sections 1, 2 & 3 on Page 2.
2. Attach a copy of:
 - (A) All applicants are required to submit, regardless if they have submitted one in the past, medical proof of diagnosis dated 2007, 2008, 2009 or 2010, which falls under Pervasive Developmental Disorder/Autism Spectrum Disorder, signed by a licensed medical professional, with the diagnosis clearly circled or highlighted. Specifically it must state one of the following diagnoses: Autism ~ Asperger's ~ PDD-NOS~Childhood Disintegrative Disorder (CDD) ~ Rhett's Syndrome
 - (B) Copy of pages 1 & 2 of your 2008 or 2009 Tax Return. **If requesting the \$150 Grant to be used for a registration fee to attend an autism-related educational, behavioral or medical conference your tax return is not required.**
 - (C) Completed and signed Grant Application.
3. Application must be postmarked no later than **February 14, 2010**. We regret that incomplete applications, those received without required documentation and/or those with a postmark beyond **February 14, 2010** will not be considered.

Mail the original, signed Application with required documentation to:

Lynn George
c/o Autism Support Daily
Grant Division
208 Lytton Road
Moon Twp., PA 15108

To join Autism Support Daily or for more information, visit us at www.AutismSupportDaily.com

**Autism Support Daily's
Winter 2010 Grant Application**

For Office Use Only: ASD Winter 2010
Grant App # _____ Deadline 2/14/2010

SECTION I: Parent/Guardian and Applicant Information

1. Person(s) Legally Responsible for Applicant:

Name(s) _____ Phone # () _____

Address _____ City: _____ State: _____ Zip: _____

Email address: _____

2. Applicant's Name (**Person to receive services/item**) _____

Applicant's Address _____ City _____ State _____ Zip _____

Phone # () _____ Applicant's Age _____ Date of Birth _____ Male/Female _____

Relationship to Applicant: Parent ___ Legal Guardian ___ Other___ (Explain)_____

SECTION II: Funds Being Requested – CHECK ONLY ONE BOX. Request only **one item** per family.

If more than one item is checked, we will consider the lesser amount.

<input type="checkbox"/>	(1) Behavioral, RDI, Occupational, Sensory Integration, Speech/Language or Physical Therapy <i>Sessions</i>	up to \$400
<input type="checkbox"/>	(2) Behavioral, RDI, Occupational, Sensory Integration, Speech/Language or Physical Therapy <i>Evaluations</i>	up to \$200
<input type="checkbox"/>	(3) Adaptive programs/adaptive sports/classes such as art, music, sports, swim/aquatics, etc.	up to \$400
<input type="checkbox"/>	(4) Supplements, prescriptions, medical treatments or laboratory testing	up to \$300
<input type="checkbox"/>	(5) Registration fee for attendance at an autism-related educational, behavioral or medical conference	up to \$150

SECTION III: DO NOT LEAVE THIS SECTION BLANK, DOING SO WILL DISQUALIFY YOUR APPLICATION.

All grant checks will be **mailed to the parent/guardian and made payable to ONE provider:** Consultant, Therapist, Facility, Doctor, Pharmacy, etc. The family is responsible for contacting the provider to purchase the item requested on behalf of their child/young adult and then submitting our check to them for payment.

Please provide us with information on the provider below.

Provider Name/Company: _____ Business License # _____

Address _____

City _____ State _____ Zip Code _____ Telephone # () _____

If the amount received from this grant will not pay the full amount needed, please explain below how the remaining balance will be paid, otherwise we will be unable to consider your application.

How did you hear about this Grant? _____

CERTIFY/SIGNATURE:

I certify that the information provided in this Application is true and accurate. I agree to have my name (parent) and the Feedback letter I will send to Autism Support Daily used by Autism Support Daily in their future grant writing efforts, as well as on their website at www.AutismSupportDaily.com

Signature of Parent/Guardian _____ **Date** _____