

## **2014 GRANT APPLICATION**

**Mail completed application to:  
NATIONAL AUTISM ASSOCIATION  
HELPING HAND PROJECT**

20 Alice Agnew Drive  
Attleboro Falls, MA 02763  
Tel: (877) 622-2884

***Please completely review the following information before filling out this application. Please print clearly. Illegible applications cannot be considered.***

**Applications must be postmarked by June 30, 2014. Applications postmarked after June 30, 2014 cannot be accepted. Please email questions to [naa@nationalautism.org](mailto:naa@nationalautism.org).**

**Autism is treatable.** The Helping Hand Project provides families with financial assistance in getting necessary medical treatment, lab testing and physician-recommended supplements and therapies for their child with autism. **Do not apply for this grant if you are seeking funds for camp tuition, respite care, fencing, trampolines, swingsets, trips to Disney World, etc.**

**This program is for those in DIRE financial need with an annual net income under \$50,000.**

### **Frequently Asked Questions**

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

A: Your child must meet all three basic criteria to apply:

1. Birth to age 21.
2. Reside in the United States of America.
3. Diagnosed with an autism spectrum disorder.

**Q: How much money can I request?**

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

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

A: First, review the three basic criteria. If you meet these, complete this application. You must attach a letter from your child's physician that confirms your child's diagnosis. You must provide a copy of your most recent tax return. If you did not file a tax return, you must provide alternate proof of income.

**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 service provider to pay for supplements/medication, therapies, medical evaluation or lab testing.

**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), your application will be reviewed by the NAA staff. No awards will exceed \$1,000 at this time. **ONLY APPROVED GRANT RECIPIENTS WILL BE CONTACTED BY NAA. If you want to confirm receipt of your application, mail with Return Receipt requested or Delivery Confirmation from the post office. Grant distribution will be completed by 8/31/2014.**

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

A: Yes.

**Q: I'm not sure if this request falls within the grant guidelines. Should I still send in an application?**

A: If your request is for something other than medical treatment, therapies, lab testing or supplements for your child with autism, it does not fall within the grant guidelines.

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

A: The guidelines of this grant do not allow payment for anything other than medical treatment, therapies, lab testing and supplements/medications for your child with autism.

**CHILD**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**MOTHER**

Mother's Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Street/City/Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**FATHER**

Father's Name: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Street/City/Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**Number and ages of other dependent children:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Outline of funding requested (Limit - one time grant of \$1,000 maximum):**

\$ \_\_\_\_\_ **(Be specific with your request and include all costs.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Doctors involved in child's treatment:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Name of other agencies or services also contacted for funding:**

Please indicate which have been contacted and total amount requested or received (if any).

Have you previously received funding from NAA? Yes \_\_\_\_\_ No \_\_\_\_\_

**SUPPLEMENTAL SECURITY INCOME (SSI) \$ \_\_\_\_\_**

**Personal Statement of Income and Financial Status of Custodial Parents or Guardians**

**ASSETS**

Checking Account \$ \_\_\_\_\_  
 Savings Account \$ \_\_\_\_\_  
 Real Estate \$ \_\_\_\_\_  
 Home Value \$ \_\_\_\_\_  
 Automobiles \$ \_\_\_\_\_  
 Personal Property \$ \_\_\_\_\_  
 Other Assets \$ \_\_\_\_\_  
**Total Assets: \$ \_\_\_\_\_**

**LIABILITIES**

Monthly House Payment/Rent \$ \_\_\_\_\_  
 Other Monthly Bills/Loans \$ \_\_\_\_\_  
 Monthly Utilities \$ \_\_\_\_\_  
 Monthly Insurance \$ \_\_\_\_\_  
 Monthly Automobile Expenses \$ \_\_\_\_\_  
 Medical Bills Due \$ \_\_\_\_\_  
 Physician/Agency \$ \_\_\_\_\_  
**Total Liabilities: \$ \_\_\_\_\_**

**Combined sources of income:**

Attach previous year's IRS return or other proof of income. Net income must not exceed \$50,000.

**INCOME TYPE**

**MONTHLY**

**ANNUAL**

Salary:	\$ _____	\$ _____
Bonuses and Commissions:	\$ _____	\$ _____
Alimony/Child Support:	\$ _____	\$ _____
Real Estate Income:	\$ _____	\$ _____
All Other Income:	\$ _____	\$ _____
<b>TOTAL INCOME:</b>	<b>\$ _____</b>	<b>\$ _____</b>

(ALL OTHER INCOME includes Grants, Social Security, CRS, Medicaid, etc.)

**Attach Doctor's Letter:** We must have a letter from your child's physician stating your child's diagnosis and confirming that your request is necessary/beneficial for your child.

The above information is freely given to expedite this grant request.

**PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**Mail completed application, doctor's letter, and most recent IRS tax return to the address shown on page 1. (Send only your main tax return form, i.e. 1040, showing taxable income. Attachments/schedules are not necessary.)**

**PLEASE NOTE: ONLY APPROVED GRANT RECIPIENTS WILL BE CONTACTED BY NAA.**

This application cannot be considered until this form is completed legibly, signed, and all supporting documents (including doctor's letter) are received. The information included in this application will be kept confidential and for internal use by NAA only. Documents will not be returned to you. Please keep a copy for your records.