HELPING HAND
|Financial Aid for Autism Families|

NATIONAL AUTISM ASSOCIATION
Northwest Indiana Chapter

2010 Helping Hand Grant Application

The NWI-NAA Helping Hand Grant Program provides families with financial assistance in obtaining necessary biomedical treatments, supplements and therapy services for their child(ren)/dependent with an Autism Spectrum Disorder. A complete list of treatments covered by this application is included in this packet. **Please do not apply for this grant if you are seeking funds for respite care, fencing, trampolines, swing sets, trips to Disney World, etc.**

This program is only intended for families in dire financial need. Priority will be given to single parents.

Therapies covered under this grant program include:

▪ Doctor Visits (Office visits and Consults) ▪ Medical Testing ▪ Supplements ▪ Chelation ▪ HBOT ▪ IVIG ▪ Chiropractic Care ▪ Neurofeedback ▪ NAET ▪ Chinese Medicine/Acupuncture ▪ ABA/VBA (including consultation) ▪ RDI ▪ Floortime ▪ Son-Rise	▪ Play Project ▪ Speech Therapy ▪ Occupational Therapy ▪ Physical Therapy ▪ Music Therapy ▪ Social Skills Groups (monitored by a licensed professional) ▪ Tuition Assistance ▪ Summer Camp Assistance ▪ Therapeutic Listening Programs ▪ Therapeutic Horseback Riding Programs ▪ Family Counseling ▪ Vision Therapy

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FREQENTLY ASKED QUESTIONS

Q: How do I know if my child qualifies for help from NWI-NAA?

A: Your child/dependent must meet the basic criteria to apply:

1. Must have a diagnosis of Autism Spectrum Disorder (Autism, PDD-NOS or Aspergers)
2. Provide proof of residency in Lake or Porter County Indiana.

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/dependent is $500.

Q: How do I apply for assistance from the NWI-NAA for my child?
A: First, review the basic criteria. If you meet these, complete a **GRANT APPLICATION**. You must attach a letter from your child's physician/psychologist that confirms your child's diagnosis. If your request exceeds $300, 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 vendor or service provider to pay for tuition, supplements/medication, medical evaluation or testing, therapies, etc.

Q: I've sent my application in. How long until I know if my application has been approved?
A: We accept applications from January 1 – May 31. We will review the Applications in June and Grants will be awarded in July. ***ONLY APPROVED GRANT RECIPIENTS WILL BE CONTACTED BY NAA-NWI. Only complete and legible applications will be considered by NAA-NWI.***

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 biomedical treatments, supplements or therapies for your child/dependent 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-NWI help us?
A: The guidelines of this grant do not allow payment for anything other than biomedical treatments, supplements or therapies for your child/dependent with autism.

Q: What is the maximum income a family can have to apply?
A: There is no income limit for this application.

Q: How often can we apply for a grant?
A: If you were not notified by July 31st that you have been awarded a grant, then we encourage you to apply again in the next calendar year beginning January 1st.

Q: If I have more than one child affected, can I apply for both?
A: Yes, you can apply for both but you must submit a separate application for each child/dependent. There is no guarantee that one or both children will receive funding.

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2010 HELPING HAND GRANT APPLICATION

The information you provide in this application form is confidential. It will be reviewed by NAA-NWI Board Members or a designated 3rd party 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-NWI 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. Grants awarded by NAA-NWI, if any, shall be at the sole discretion of NAA-NWI.

INFORMATION ABOUT THE CHILD/DEPENDENT IN NEED OF FUNDING

Name: _____ Age:_____ Date of Birth: _____

Medical Diagnosis or

Disability/Disabilities:_____

_____

Please tell us more about the child/dependent, his/her needs and

challenges:_____

_____

_____

MOTHER

Mother's Name:_____

Marital Status: _____ Telephone: _____ Email: _____

Street/City/Zip:_____

Employer:_____ Telephone: _____

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Employer Address:_____

FATHER

Father's Name**:**_____

Marital Status: _____ Telephone: _____ Email: _____

Street/City/Zip:_____

Employer:_____ Telephone: _____

Employer Address:_____

Number of other dependent children:_____ **Ages:** _____

Number of other dependents: _____ **Ages:** _____

Outline of funding requested ($500 maximum per child/dependent):

$_____ (Be specific and include all costs.)

_____

_____

_____

_____

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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 NWI-NAA? Yes_____ No_____

SUPPLEMENTAL SECURITY INCOME (SSI) $_____

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

ASSETS		**LIABILITIES**	
Checking Account	$_____	Monthly House Payment/Rent	$_____
Savings Account	$_____	Other Monthly Bills/Loans	$_____
Real Estate	$_____	Monthly Utilities	$_____
Home Value	$_____	Monthly Insurance	$_____
Automobiles	$_____	Monthly Automobile Expenses	$_____
Personal Property	$_____	Medical Bills Due	$_____
Other Assets	$_____	Physician/Agency	$_____
Total Assets:	**$_____**	**Total Liabilities:**	**$_____**

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Combined sources of income:

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

INCOME TYPE	**MONTHLY**	**ANNUAL**
Salary:	$_____	$_____
Bonuses and Commissions:	$_____	$_____
Alimony/Child Support:	$_____	$_____
Real Estate Income:	$_____	$_____
All Other Income:	$_____	$_____
TOTAL INCOME:	**$_____**	**$_____**

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

Please attach:
1. Most Recent Tax Return (if your request is over $300)

2. Doctor's Letter:
We must have a letter from your child's/dependent's physician/psychologist 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.

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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 – Northwest Indiana Chapter (NAA-NWI). I understand that by signing this form I waive my right to hold NAA-NWI 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 tax returns (if applicable) to:

NAA-NWI
Attention: Helping Hand Program
PO Box 216
Hobart, IN 46342

Applications *MUST* be postmarked by May 31st in order to be considered for the current year's program.

The information included in this application is confidential and for NAA-NWI 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.