



16052 Swingley Ridge Road; Suite 205; Chesterfield, MO 63017; 636-449-0352

## **FINANCIAL ASSISTANCE APPLICATION FORM**

### **PLEASE NOTE THE FOLLOWING APPLICATION TERMS**

- a. Applications must be on behalf of a specific child aged 17 or under at the time of the application who resides within a 250 mile radius of St. Louis, Missouri.
- b. Funding is available only for families of a child affected by Autism and must be for services/therapies/schooling/programs deemed to benefit said child.
- c. Please complete a separate form for each child.
- d. All financial information pertains to the parent/guardian of the applicant child. Please note that funding allocations of greater than \$1,000 in a one (1) year period may require additional financial data, including tax returns, bank statements, pay stubs, etc.
- e. The form must be signed by the parent or legal guardian of the child whom services are applied for.
- f. Please complete this Application Form in its entirety, even if you have applied for funding from ACTION FOR AUTISM before, attaching extra pages as needed.

#### **1. Applicant Details (information on the child services are requested for)**

Child's Name: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Diagnosis: \_\_\_\_\_

Age at Diagnosis: \_\_\_\_\_

Diagnosed By: \_\_\_\_\_

Child's School(s): \_\_\_\_\_

#### **2. Family Information (information on parent(s)/guardian(s) of the above child)**

Parent/Guardian Name(s): \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Best Time to Contact: \_\_\_\_\_

Marital Status:  
 Married/Cohabiting     Single Parent     Widowed     Divorced/Separated

Who referred you/how did you learn about ACTION FOR AUTISM: \_\_\_\_\_

**3. Services Requested**

Service(s) Needed: \_\_\_\_\_

Benefit(s) To Be Gained: \_\_\_\_\_

Frequency (per week): \_\_\_\_\_

Duration (in months): \_\_\_\_\_

If you currently work with an Organization/Company for Services, please include the information below.

Organization Name: \_\_\_\_\_

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

Organization Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Organization Fees: \_\_\_\_\_

Accreditation(s): \_\_\_\_\_

**4. Financial Information**

**4.1 Parent/Guardian Financial Status**

(Please Circle)

|   |                       |                              |
|---|-----------------------|------------------------------|
| Total GROSS Earnings of Parents/Guardians | \$ _____              | Per Week/Month/Year          |
| Additional Income                         | Benefits              | \$ _____ Per Week/Month/Year |
|   | Child Support/Alimony | \$ _____ Per Week/Month/Year |
|   | Pension               | \$ _____ Per Week/Month/Year |
|   | Disability            | \$ _____ Per Week/Month/Year |
|   | Maintenance           | \$ _____ Per Week/Month/Year |
|   | Other                 | \$ _____ Per Week/Month/Year |

**4.2 Parent/Guardian Employer Information**

Father/Guardian 1 Job Title: \_\_\_\_\_

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

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Mother/Guardian 2 Job Title: \_\_\_\_\_

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

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

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**4.3 Parent/Guardian Financial Commitments (i.e. house payment, car payments, credit card bills, etc.)**

| AMOUNT | TO WHOM | DURATION | REASON |
|--------|---------|----------|--------|
| \$     |         |          |        |
| \$     |         |          |        |
| \$     |         |          |        |
| \$     |         |          |        |
| \$     |         |          |        |
| \$     |         |          |        |
| \$     |         |          |        |

Other Dependant Children: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please explain any special circumstances pertaining to your financial situation, either temporary or long-term (i.e. medical bills, job loss, layoff, etc.):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. Other Information**

What other services/therapies has your child received, and what type of results were achieved:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What benefits will the funding of ACTION FOR AUTISM bring to your child and your family:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What time & day of the week would be best for you to meet with the Officers/Board Members of ACTION FOR AUTISM to discuss your child's needs and the availability of funding:

\_\_\_\_\_  
 \_\_\_\_\_

Please include any comments or other information you wish to share below:

\_\_\_\_\_  
 \_\_\_\_\_



I hereby confirm that I have provided within this Application Form all requested information to the best of my knowledge. I understand that failure to disclose full details or falsifying information could invalidate my Application and allow for further legal action by ACTION FOR AUTISM.

Name (printed): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return completed application, along with any necessary documentation, to:

ACTION FOR AUTISM  
ATTN: Application Processing  
16052 Swingley Ridge Road, #205  
Chesterfield, MO 63017

Once your application has been reviewed, you will be contacted by a member of the ACTION FOR AUTISM team. Thanks for your interest in ACTION FOR AUTISM.

\*\* ACTION FOR AUTISM does not discriminate against individuals on the basis of race, color, sex, sexual orientation, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin in the administration of its funding.

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### ACTION FOR AUTISM USE

Date Received: \_\_\_\_\_

Via: \_\_\_\_\_ Review: \_\_\_\_\_ Contact: \_\_\_\_\_

Interview Info: \_\_\_\_\_

Other: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_