Reaching 4 Autism Miracles
2015 Application for Grant

Reaching 4 Autism Miracles (R4AM) was founded to promote the education and awareness of childhood autism. Among others, a mission of R4AM is to generate community support to assist families whose children are affected by autism. Through this community support, the R4AM Grant Program was proudly established to provide financial assistance to families whose children are affected by autism for purposes of providing for such children's therapy, advocates, education and other related purposes that are otherwise not covered by insurance or private/public funding.

To be considered for R4AM grants, applicants must meet specific criteria and complete the attached application. It is understood that the majority of applications will be completed by an applicant's parent or guardian. However, it is further understood that a grant award is to be used for the benefit of the applicant and will be payable to the provider of the applicant's services and/or treatments.

The number and amount of grants to be awarded will be determined by R4AM's annual fundraising activities and community donations. The Board of Directors will determine the number and amounts of each grant annually. Grants are awarded individually on a one-time basis and there are no recurring awards. A new application will need to be submitted in each term grants are offered.

The awarding of R4AM grants will be based on the following:

- Financial need
- History, need and amount of treatment
- Applicant's written narrative

The following must be sent to R4AM in order to be eligible for grants:

- Completed grant application
- Proof of diagnosis
- Information of provider to which grant will be payable (including costs of treatment(s))
- Copy of Previous Year's Tax Returns

Grant applications will be reviewed by the R4AM Board of Directors who will make decisions on grant awards. **Applications must be postmarked on or before November 10, 2015. Applications by fax or email will not be reviewed.** Please send completed applications to:

Reaching 4 Autism Miracles
Attn: Grant Applications
42577 Olmsted Drive
Ashburn, VA 20148

Reaching 4 Autism Miracles
2015 Application for Grant

Please type or print clearly in the form below.

Today's Date: _____

General Information

Applicant's Name (Child affected by Autism Spectrum):	Applicant's Date of Birth:	
Applicant's Current Age:	Applicant's Gender: ☐ FEMALE ☐ MALE	
Street Address:		
City:	State:	Zip Code:
Guardian(s) Name(s):		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address:	
Number of other minor dependents in household:		

Health/Insurance Information Release

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the R4AM grant review process. I give R4AM permission to verify treatment information by contacting the treatment vendors directly. This authorization shall be valid for one year unless otherwise stated. I understand that I may revoke this authorization in writing at any time.

_____ _____

Signature Date

Date of Diagnosis:

Please feel free to attach any supplemental information (current IEP, physician diagnosis, BIP)

History of Treatment

Type of Treatment	History of Treatment	Frequency (i.e. 2 hrs per week)	Provider of Services
Speech Therapy	☐ Yes ☐ No		
Occupational Therapy	☐ Yes ☐ No		
Physical Therapy	☐ Yes ☐ No		
Applied Behavior Analysis	☐ Yes ☐ No		
Social Skills Groups	☐ Yes ☐ No		
Other: (please explain)	☐ Yes ☐ No		

Request of Grant Funds
(Supportive documentation must include cost of treatment/items.)

Direct Treatment

Total Cost of Treatment Monthly:
$

Supportive Documentation Attached: □ Yes □ No (If "No" application will not be considered)

Grant Request is for the following Service/Intervention(s):

Provider Name:

Provider Contact Telephone Number:

Street Address:

City: State: Zip Code:

Describe details: (Include who will provide treatment, frequency and duration of treatment, etc.)

Assessments or Testing

Total Cost of Assessment/testing monthly:
$

Supportive Documentation Attached: □ Yes □ No (If "No" application will not be considered)

Grant Request is for the following Service/Intervention(s):

Provider Name:

Provider Contact Telephone Number:

Street Address:

City: State: Zip Code:

Describe details: (Include who will provide testing at what frequency and purpose)

Request of Grant Funds (continued)
(Supportive documentation must include cost of treatment/items.)

Materials

Total Cost of Assessment(s) monthly:
$

Grant Request is for the following Service/Intervention(s):

Provider Name: Provider Contact Telephone Number:

Street Address:

City: State: Zip Code:

Describe details: (Include reason materials required)

Financial Information

Guardian #1 Current Monthly Gross Income:	Please attach copy of previous year's Tax Return
Guardian #2 Current Monthly Gross Income:	Please attach copy of previous year's Tax Return
Other Sources of Income:	
Source: Child Support	Monthly Gross Amount: **$**
Source:	Monthly Gross Amount: **$**
Source:	Monthly Gross Amount: **$**

Funding Sources
(including other grants or scholarship awards)
Check all funding sources that apply and complete the requested information.

☐ **Private/Health Insurance**
Insurance Company: Contact Person: Telephone Number:

Treatments Covered:

Services Provided:

☐ **School System**
School System: Contact Person: Telephone Number:

Services Provided:

☐ **County**
County: Contact Person: Telephone Number:

Services Provided:

☐ **Other**
Describe: Contact Person: Telephone Number:

Services Provided:

Description of Family Situation

Please describe in one page or less your family situation. Please do not send photos or videos. You may use the space below or attach a separate sheet. If you attach a separate sheet please check this box. □

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CONSENT AND RELEASE

I hereby authorize and consent R4AM to use photographs, reproductions, video and/or other digital images or recordings of me or my child, whether provided by me, my child or otherwise, for the exclusive use of R4AM for publicity, fundraising, endorsement or any other related purposes. Further, I authorize and hereby consent R4AM to use my or my child's testimony, whether in written or voice form, for the purposes named above.

In connection with the forgoing, R4AM shall have the following rights to such material:

1. The use of my or my child's first name (names may be withheld below), images, videos, written testimony and voice for R4AM's website, educational materials or publicity or for any other legitimate reason.

2. The use, reproduction, publication and/or distribution of my or my child's images, videos and/or recordings for the use of brochures, motion pictures or other media related purposes.

3. To record, reproduce, and amplify such material.

I hereby release and hold harmless R4AM from any and all liability arising from the use of the above material, including, but not limited to, any and all claims for invasion of privacy, libel, reproduction and/or dissemination of use in the public media. Further, by signing below, I hereby waive the right to inspect or approve my/my child's image or any finished materials that incorporate my image. I understand and agree that I will receive no compensation, now or in the future, in connection with the use of my/my child's image.

I represent that I have read the preceding and completely understand the contents.

Parent/Authorizer's Name: _____

Child's Name: _____

Signature of Parent or Guardian: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Authorized Use of Name (please circle one): Yes No