



The Autism Resource Foundation

APPLICATION FOR SUPPORT

701 Andrew Jackson Way NE, Suite 219 | Huntsville, AL 35801-3504 | (877) 455-3092
www.theautismresourcefoundation.org | Helping Families Combat Autism

The Autism Resource Foundation (ARF) Scholarship Program has been established to provide financial assistance in getting necessary biomedical treatments, supplements, therapy and educational resources for children with autism spectrum disorders in North Alabama and the Tennessee Valley region. This program is intended ONLY for parents and caregivers in serious financial need. **All scholarships are based on availability of funds.**

Instructions:

1. Please read instructions carefully and print clearly. If this form is incomplete, inaccurate, or not signed, it will not be considered.
2. Please complete one application for each individual or organization.
3. The Autism Resource Foundation may require an attached written statement describing educational goals and other relevant information (*see specific scholarship criteria*).

Applicant Information:

Name: _____ Gender: Male Female

Date of Birth: _____ Ethnicity: African American Caucasian Hispanic Asian Multi-Racial/Other

Parent/Caregiver's Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #'s: (home) _____ (work) _____ (cell) _____

Email: _____

Amount Requested: _____ If we have limited funds available, would you consider a partial scholarship? Yes No

Brief Description of Need: _____

Service Provider's Name/Organization (if requesting services): _____

Approximate Income of Parent/Caregiver:

- Under \$30,000 \$31,000 to \$50,000 \$51,000 to \$75,000 \$76,000 to \$100,000 Over \$100,000

Family Size: 1 2 3 4 5 6 7 8 or more

Eligibility:

1. Applicant must reside in the North Alabama / Tennessee Valley region.
2. Applicant must be diagnosed with a Pervasive Developmental Disorder (Autism, Asperger's, CDD, Rett's, or PDD-NOS).

Specific Scholarship Criteria:

1. If applying for an individual, please attach a letter from the physician and/or establishment confirming diagnosis.
2. If applying for therapy, please attach a written statement from the service provider describing the proposed therapy and associated costs. Be sure to include specific contact information for the service provider.
3. Although not required, a most recent tax return (or other proof of income) is recommended.
4. Although not required, proof of residency is also recommended.

References:

Please provide at least two references with no more than one family member (the other being former employer, teacher, minister, neighbor, etc.) whom we may contact if necessary.

	Name	Relationship	Address	Phone #1 (home)	Phone #2 (cell)
Reference #1			Street: _____ City: _____ State: ____ Zip: _____		
Reference #2			Street: _____ City: _____ State: ____ Zip: _____		

Volunteer Information:

The Autism Resource Foundation recognizes that many families do not have financial resources but do have talent and energy which can be used to help us provide resources and advocate on behalf of families facing the burden of ASDs and PDDs. Although not a requirement or discriminator to receiving support, we do ask if the applicant can make any contribution in helping others. Please check all that apply:

- I can answer phones at The Autism Resource and Knowledge Center.
- I can work booths at conferences and workshops.
- I can work from home (addressing mail-outs, researching, etc.)
- I have the following skill sets (web designer, Microsoft Office, etc.): _____
- _____
- Other areas from which to make a contribution of time or resources: _____
- _____
- I am not in a position to volunteer at this time.

Justification:

Please provide any relevant personal or family circumstances which make this request necessary: _____

I certify that the statements herein are true to the best of my knowledge and grant my permission for the information contained herein to be shared with the scholarship selection committee(s). I am not a member of The Autism Resource Foundation. If I am chosen as a recipient of this scholarship, I authorize payment to be made directly to the vendor or service provider. If I leave the service provider prior to the depletion of funding from this scholarship, the remaining balance will be returned to the Foundation.

Signature: _____ Date: _____

Completed applications, with all applicable signatures and attachments, may be submitted electronically by email to: admin@theautismresourcefoundation.org or by mailing to the following address:

The Autism Resource Foundation
Attn: Grant Dispersal Committee
701 Andrew Jackson Way NE, Suite 219
Huntsville, AL 35801-3504

