Dayton Autism Society
Family Grant Application

Physician Statement

The Autism Society of Dayton offers children and adults living in Montgomery, Greene, Warren, Miami, Preble, Darke, Champaign, Clark, Shelby, Logan, and Butler counties who have a diagnosis of Autism Spectrum Disorder the opportunity to request consideration for a Grant, not to exceed $250.00. The purpose of this Grant is to assist those in financial need to pay for things like therapy, respite care, supplies, equipment and other expenses not covered by insurance.

The person named below has applied for a grant through the Autism Society of Dayton. A requirement of the application process is providing confirmation of Autism Spectrum Disorder by a licensed physician.

To be completed by Requesting Parent/Legal Guardian:

Grant is being requested for [Name]: _____

Date of Birth_____/_____/_____

Requesting Parent/Legal Guardian Name: _____

Tel: [_____] _____ email _____

Complete Home Address: _____

To be completed by Licensed/Treating Physician:

Physician Name/Practice: _____

Complete Address: _____

Please check the appropriate box and sign below:

☐ This individual *does* have an Autism Spectrum Disorder Diagnosis

_____ _____
Physician's Signature Date

☐ This individual *does not* have an Autism Spectrum Disorder Diagnosis

_____ _____
Physician's Signature Date

This document to be returned to DAS along with the completed Grant Request by the requesting Parent/Guardian

Dayton Autism Society
Family Grant Application

Children and adults living in Montgomery, Greene, Warren, Miami, Preble, Darke, Champaign, Clark, Shelby, Logan, and Butler counties who have a diagnosis of Autism Spectrum Disorder may request consideration for a Grant, not to exceed $250.00. The purpose of this Grant is to assist those in financial need to pay for things like therapy, respite care, supplies, equipment and experiences not covered by insurance. **Mail completed application to Autism Grant Committee 4801 Springfield St. Dayton OH 45431 or email grantreview@autismsocietyofdayton.org .** Failing to complete the form in its entirety or provide required information or documentation may result in delay or denial of request. – We will treat your personal information with the utmost care and respect your privacy. Only those who are authorized to see this document for Grant review and approval purposes are permitted to see it. To preserve your privacy, Grant applications are stored in a secured location, and upon pre-determined, Board approved timelines, will be appropriately destroyed/ shredded.

Date of Application _____/_____/_____

Grant is for [Name]: _____ Date of Birth_____/_____/_____

Complete Home Address: _____

Requesting Parent/Legal Guardian Name: _____

Address: _____

Tel: [_____] _____ email _____

☐ There are more than one family members with ASD in my household

[Effective 1/1/17]Grant requests require documentation confirming diagnosis of Autism Spectrum Disorder. This confirmation must be provided by a licensed physician, and will only be required one time. When submitting your request, please check the appropriate box below.

☐ I have received an ASA-Dayton Grant previously and completed documentation by a licensed physician confirming diagnosis of Autism Spectrum Disorder is on file. Date of prior/last ASA-Dayton Grant: _____

☐ This is my first request for an ASA-Dayton Grant. I have attached completed documentation by a licensed physician confirming diagnosis of Autism Spectrum Disorder [*failing to attach documentation may result in delay or denial of request*].

Amount Requested [Not to exceed $250.00] $_____

Please check the appropriate box below and provide details regarding your request. Be as specific as necessary to help us in our consideration. Attach additional pages if needed.

☐ Bio Medical Treatment/s [Dr. Visits, lab test, supplements, treatments] ☐ Camp ☐ Respite/Child Care
☐ Therapy [OT/PT/ABA/Social Skills groups Recreational] ☐ Un-covered Medical Care costs related to the Diagnosis
☐ Equipment [medical/augmentative communication devices, therapeutic]

_____

_____

_____

_____

☐ I request the funds to be distributed to parent/caregiver/guardian as named on this application
☐ I request the funds to be distributed directly to the provider (name and address of provider below):

_____

DAS Committee Use Only
Received Date:_____ Action _____ #_____Date _____ initial_____
Notes: _____
_____