



2016 Technology Grant Instructions

The Autism Alliance of NENY will purchase technology devices for local individuals with an Autism Spectrum Disorder. The decisions will be made at the discretion of AANENY Grant Committee, but preference will be given to individuals most likely to use the device for communication. All grants are chosen through our selection process and will be reviewed by the Board of Directors. This application should include items such as iPads, iPods, tablets, GoTalk or other communication devices.

In order for an individual to be eligible, they must meet the following criteria:

- Have diagnosis (medical or educational) of an Autism Spectrum Disorder. Please include supporting documentation.
- Have significant communication delay.
- Live in Northeastern New York. Preference will be given to those within Clinton, Essex and Franklin Counties.
- Have access to a computer and internet (at home, school or somewhere readily accessible).
- Have a justification for requested device from a professional who is currently working with the applicant (Speech Language Pathologist, Teacher, Counselor, Autism Consultant, Direct Care Staff, etc). Please include justification.
- Demonstrate financial need.
- All information will be confidential and be used solely for the purpose of selection. First name and initial may be used in advertising if permission is granted.

Completed application and all supporting documentation must be postmarked by July 1, 2016 and can be sent to:

Autism Alliance of NENY
Attention: Grants
P.O. Box 1884
Plattsburgh, NY 12901

Please e-mail grants@aaneny.org with any questions.



2016 Technology Grant Application

Applicant Name: _____ **Age:** _____

Address: _____

Phone Number: _____ **E-mail:** _____

Contact Person: _____ **Relationship to Applicant:** _____

Household Composition (Name, age, relationship):

Household Income (Salary, Alimony, Child Support, SSI, Public Assistance):

Have you previously applied or received a grant? If yes, what was requested? _____

If awarded, who will attend training? Individual / Parent / Teacher / SLP / Other _____

I verify that all information provided in this application is true and accurate. I understand that any falsification would disqualify this application. I give permission to the above stated professionals to share information in regards to diagnosis and ability to benefit from technology.

I understand that the device may be used to teach any number of different skills, and while it can be used as a communication device, it can also be used to facilitate any skill development that can be considered beneficial.

Signature: _____ **Date:** _____

I authorize Autism Alliance of Northeastern NY to publicize first name and first initial of last name of the recipient. (Optional- does not impact decision)

Signature: _____ **Date:** _____

For Official Use Only

Application # _____



2016 Technology Grant Application

Professional providing Diagnosis

Name: _____ Profession: _____

Address: _____

Phone Number: _____ E-mail: _____

Professional providing Technology Recommendation

Name: _____ Profession: _____

Address: _____

Phone Number: _____ E-mail: _____

Device Recommended iPod / iPad Mini / iPad / Other _____

Signature: _____ Date: _____

Please describe the communication needs of the applicant including level of language, understanding and communicative intent:

Does the person currently use any assistive technology? What has been successful? What has not?

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Application # _____

Review Date