KNOWAutism
A Foundation for Children with Autism

2019 Autism Diagnostic Assistance Program

The Autism Diagnostic Assistance Program provides scholarships for diagnostic testing to financially disadvantaged families with children between the ages of 12 months and 14 years of age.

We provide financial assistance ranging from $500 to $1,500 per child to help pay for the cost of diagnostic testing for Autism Spectrum Disorder.

The Program Committee evaluates applications based a number of different criteria. For approved applications, the Committee selects the grant amount to be awarded based upon available funding and the demonstrated financial need of the eligible applicants. Awards are one time only.

Eligibility Requirements:

1. Applicants must demonstrate a need for financial assistance and provide relevant information for the committee to review.
2. Applicants must be the parent or legal guardian of the child, and the child must be between the ages of 12 months and 14 years of age.
3. Applicants must submit a complete application. If the family is seeking assistance for more than one child, a separate application must be submitted for each child.

Review Process:

The Program Committee reviews applications on a rolling basis and selects a limited number of applicants to receive financial support scholarships. A member of the committee may contact you to request additional information or documentation if needed.

The time it takes for an application to be reviewed varies. However, if you have not been contacted within 2 weeks of submitting your application, you may request an update or confirmation that your application has been received.

All applicants will receive notice of the decision made on their application. Typically, a committee member will contact you at the e-mail or mailing address provided on your application to notify you of the committee's decision.

Award Acceptance Requirements:

If you are selected to receive assistance, you will receive an award letter and an acceptance agreement, which must be read, signed, and returned.

You will also be asked to provide a photo of the scholarship recipient and grant KNOWAutism Foundation permission to use your child's photographic likeness in its publications, social media, website, fundraising materials, and/or other media. Recipients must also provide a thank you note or letter explaining how the award will impact your family.

All scholarship checks will be issued in the name of the provider or facility of your choice for your child's diagnostic assessment, as indicated on your application and agreement.

Confidentiality of Personal Information:

KNOWAutism Foundation values your trust and understands the importance of protecting your privacy. All applications and documentation provided will be maintained in confidence, in accordance with the Foundation's privacy practices.

Any Personal Health Information you provide will be considered confidential and will only be used or discussed as appropriately required in connection with the review of your application, provision of requested services, and the Foundation's work.

Some information provided in your application or award agreement may be anonymized and/or aggregated with other data for use in reports or publications for purposes such as reporting for donors/grants, outreach and awareness initiatives, or fundraising efforts in support of our mission. Except as outlined above, we will not use or disclose your personal information unless we receive your authorization and consent.

2019 AUTISM DIAGNOSTIC ASSISTANCE APPLICATION

Full Name (Parent/Guardian): ______________________________

Street Address ______________________________ Apt/Suite/Unit __________

City __________________ State __________ Zip Code __________

Phone ______________________ Is it okay to leave a Voicemail? ___ Yes ___ No

E-mail ______________________________

How did you hear about KNOWAutism? ______________________________

Date of Application ______________________

CHILD'S INFORMATION

Child's Full Name ______________________________

Date of Birth ______________________ Social Security (last 4 digits) __________

Please briefly describe the child and why you are seeking clinical evaluation for ASD. Include any information that you believe would be helpful for our consideration.

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FACILITY / PROVIDER INFORMATION

Facility/Provider Name: ____________________

Street Address ____________________ Apt/Suite/Unit __________

City ____________ State __________ Zipcode __________

Contact Person ____________________ Title/Role __________

Phone ____________ E-mail ____________________

Diagnostic Assessment Fees (Total) ____________________

Your out-of-pocket responsibility ____________________

FINANCIAL INFORMATION

Gross Annual Income *(total household)* $____________________

Household Size __________ How many are dependents? __________

Please describe your financial situation and why you are seeking assistance. Please include relevant information explaining why the cost of assessment creates financial strain or hardship.

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Please list all additional sources of financial support your family is receiving, including any pending applications for assistance (i.e. scholarships, grants, Medicaid, SSI, food assistance, child support, etc.)

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Have you previously been awarded a grant from KNOWAutism? ___ Yes ___ No

If yes, list year(s) and award amount(s) ______________________________________

Is there anything else you would like for us to know?

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SIGNATURE

By signing this form, you certify that all answers provided are true and complete to the best of your knowledge. You also certify you have read and understand the eligibility requirements, review process, acceptance requirements, and statement on confidentiality provided with this application

By submitting this application and providing your personal information to us, you accept and agree to be contacted by a representative of the Foundation and to have your personal information used by the Foundation for the purposes of reviewing your application and/or providing requested services, in accordance with our privacy practices.

Signature ______________________________________ Date ______________

Applicant Name (Print) ______________________________________

SUBMISSION

Submit completed applications to info@know-autism.org using a typed digital copy or *clear* scanned copy, or mail printed application to the address below:

KNOWAutism Foundation
Attn: Diagnostic Assistance Program
6430 Richmond Ave, Suite 410
Houston, TX 77057