Hope for Michael Relief Fund/Financial Assistance (Other) Application Form

Date:_____

Application Guidelines & Criteria

All applicants must provide all required documentation which may consist of the following documents: Medical Diagnosis of Disability (Autism), Proof of Residency, Proof of Medical Insurance and any additional documentation the organization deems necessary to provide assistance. Requested documentation not received may cause disqualification of applicant.

*****Child must be between 3-12 years old***
*****Child must have Autism diagnosis***
*****One application per family***
*****Must reside in the New York Lower Hudson Valley areas***

*If applicant **meets criteria**; completed **Assistance Application (Other) & Financial Assistance Application** must be completed in its entirety and submitted with all required documentation. **All** applications will be evaluated upon receipt for consideration of assistance requested.*

Applicant:

Childs Name:_____
Date of Birth:_____Age:_____Sex:_____
Diagnosis:_____Date of Diagnosis:_____
Address:_____
Description of Assistance Requested:_____
_____
Cost of Assistance: _____

Person making request:

Mother
Last:_____First:_____Middle Int:_____
Address:_____
City/Town:_____County:_____
State:_____Zip Code:_____
Date of Birth:_____Age:_____
Contact Telephone Number:
Home:_____Cell:_____Work:_____
Email_____Occupation_____
Place of Employment:_____

Father
Last:_____First:_____Middle Int:_____
Address:_____
City/Town:_____State:_____ZipCode:_____
Date of Brith:_____Age:_____
Contact Telephone Number:
Home:_____Cell:_____Work:_____
Email:_____Occupation:_____
Place of Employment:_____

Legal Guardian
Last:_____First:_____Middle Int:_____
Address:_____
City/Town:_____State:_____ZipCode:_____
Date of Brith:_____Age:_____
Contact Telephone Number:
Home:_____Cell:_____Work:_____
Email:_____Occupation:_____
Place of Employment:_____

Applicants' School
Name of School:_____Grade:_____
Addresss:_____
City/Town:_____County:_____
State:_____Zip Code:_____
Telephone:_____Fax:_____
School ContactPerson:_____Phone:_____

Why isn't the school providing services (assistance being sort)?_____
_____

Additional Information:

How many people live with applicant?_____
Have you applied for assistance from any other organization? **(If so, please list name of organization)**_____
_____
What response did you receive from organization?_____
_____
Please tell us how your child will benefit from assistance requested_____
_____
_____
_____
_____
_____
_____
Please describe all costs associated with assistance requested:_____
_____
_____
Please provide all documentation supporting cost of assistance requested:_____
_____

I hereby certify that all information submitted and included on the application and all statements are true. I acknowledge that any false or omissions of information may result in dismissal or disapproval of my application. I also acknowledge that this will also constitute disapproval and prohibit my child to any future consideration through the Hope for Michael Relief Fund and its associated programs. Hope for Michael reserves the right to recover any device or equipment which was awarded and not utilized for the intended applicant listed in the above application.

Signature:_____
Date:_____