Hope for Michael Relief Fund/Assisted Technology Program
Assistance Application Form

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 and be nonverbal***
*****One application per family***
*****Must reside in the New York Lower Hudson Valley areas***

*If applicant **meets criteria**; completed **Assisted Technology Assistance Application & 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.*

Application Date:_____

Applicant

Childs Name:_____
Date of Birth:_____Age:_____Sex:_____
Diagnosis:_____Date of Diagnosis:_____
Address:_____
Description of Assistive Technology requested:_____
Where will the device be utilized? _____
Cost of device: _____How will Assistive Technology assist the applicant?
_____

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:_____

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 an assistive technology device?_____
_____

Have you requested one and what was the schools response?_____
_____
_____

Have you had an Assistive Technology evaluation conducted?_____
If yes, please send copy of evaluation with application.

Family Medical Insurance

Primary Insurance:_____
Insured's Name:_____

Secondary Insurance:_____
Insured's Name:_____

Please describe in detail any dilemmas you have experienced in getting your insurance to cover any medical costs/equipment/treatment/therapy for the applicant: _____
_____
_____
_____
_____

Additional Information

How many people live with applicant?_____
Have you applied for assistive technology with any other organization? **(If so, please list name of organization)**_____
_____
What response did you receive from organization?_____
_____
Who will be utilizing the assistive technology device with child?_____
_____
Please tell us about your child's experience with assistive technology devices and how he/she has benefited from them._____
_____
_____
_____
_____
_____
_____

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:_____

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