



“Hope for Michael Relief Fund”

**Emergency Financial
Assistance Application Form**

Application Guidelines & Criteria

To qualify for Emergency Financial Assistance all applicants must have a child medically diagnosed with Autism and have had one of the following events occurred:

***Loss of Home:** Fire, Foreclosure, natural disaster*

***Loss of Employment** (to no fault of applicant)*

***Loss of Spouse:** Divorce; receiving no child support, death of primary income provider*

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

Criteria:

*****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 **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: _____

Person making request

Last: _____ First: _____ Middle Int: _____

Relationship to Child with Autism: _____

Address: _____

City/Town: _____ County: _____

State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

Contact Telephone Number:

Home: _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

Place of Employment: _____

Childs Name: _____ Age: _____ DOB: _____

Diagnosis: _____ Date Diagnosed: _____

Occurrence that occurred (list all details of event) _____

Date of Occurrence: _____ Time of Occurrence: _____

Loss of Employment (list detail explanation for loss): _____

Loss of Home (list detail explanation for loss): _____

Assistance Requested (describe): _____

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.

Signature: _____

Date: _____

Please submit application and all required documents to:

Hope for Michael, Inc.
PO Box 49, Lake Peekskill, NY 10537
Phone: (845) 528-5758, Fax (845) 528-5758
www.hopeformichaelrivera.com

All assistance based upon available funding!