KNOWAutism
A Foundation for Children with Autism

# Autism Diagnostic Assistance Program

The Autism Diagnostic Assistance Program provides scholarships for diagnostic testing to financially disadvantaged families with children between the ages of 18 months and 18 years old. We will provide financial assistance ranging from $500 - $1,500 per child to help pay for the cost of diagnostic testing for Autism Spectrum Disorder. Awards are one time only. The exact award amount is based on demonstrated financial need and available funds.

## Eligible Applicants:

The family must demonstrate a need for financial assistance and provide relevant information for the committee to review. The individual being tested must be at least 18 months of age and not older than 18 years of age.

## 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. All applications and documentation provided remain confidential during the review process. If you are selected to receive a financial support scholarship, a committee member will contact you at the e-mail or phone number provided on your application.

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## AUTISM DIAGNOSTIC ASSISTANCE PROGRAM APPLICATION

*Date of Application:* ______________________________

**Full Name (Parent/Guardian):** ______________________________

Address: ______________________________

City ______________________ State ____________ Zip ______________

Phone: ______________________ Cell: ______________________

E-Mail: ______________________________

Have you received assistance from KNOWAutism in the past? ______Yes __________No
If yes, when? ________________ Amount of the grant?_____________________

## Child Information

**Child's Full Name:** ______________________________

Date of Birth: ______________________ Social Security #: ______________________

*Briefly describe the child and why you are seeking a clinical evaluation for Autism Spectrum Disorder (ASD). Please include any information that you believe would be helpful for our consideration.*

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## Testing Center/Clinic Information

**Facility Name:** ______________________________

Address: ______________________________

City ____________________ State __________ Zip __________

Contact Person: ______________________________

Phone: ____________________ E-mail: ____________________

**Diagnostic Testing Fees (Total):** ______________________________

Do you have health insurance? ____Yes ________No

Your Out-of-Pocket Responsibility: ______________________________

## Financial Hardship

Describe your particular financial situation and why you are seeking financial assistance.

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## Financial Information

Gross Annual Household Income: ______________________ Number of Dependents: _______

Additional sources of financial support (Social Security, Medicaid, other grants, etc.):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Signature

*By signing this form, you certify that all answers provided are true and complete to the best of your knowledge.*

**Signature:** ________________________________________________ **Date:** ______________

Name (Print): ____________________________________________________________________

## Submission Instructions

Completed applications may also be e-mailed to:

E-mail: info@know-autism.org

or

Please fill out completely, sign, and return to:

KNOWAutism Foundation
Attn: Tuition Assistance Program
6430 Richmond Avenue, Suite 410 Houston, TX 77057