PANHANDLE AUTISM SOCIETY

2018 Individual Family Grant Application

Official Use Only	
Rec'd	_____
Complete	_____
Initial Review	_____
Final Review	_____
Decision: Grant	$_____
	Date _____
Decline	_____
	Date _____
Report	_____

All applications and documentation must be postmarked no later than 6/8/18

Funding requested for:

Name: _____

Date of Birth: _____

Diagnosis: _____

Parent/Guardian information:

Name: _____

Address: _____

_____

County: _____

Phone: _____

Email: _____

Are there restrictions on the ways in which we may contact you?

_____

_____

Approved needs funded by this grant must not be eligible for Medicaid or private insurance funding such as sensory equipment, assistive technology, biomedical needs and safety equipment. Total funding for these mini-grants is limited *NEW GRANT RECIPIENTS WILL BE CONSIDERED FIRST FOR THE 2018 GRANT CYCLE! IF YOU APPLIED AND RECEIVED A GRANT WITHIN THE LAST 2 YEARS, YOU MAY APPLY, BUT TOP CONSIDERATION WILL GIVEN TO NEW APPLICANTS FOR THE JUNE 2018 GRANT CYCLE!* Not everyone who applies for this grant will be funded. Applicants must be a resident of one of the five northern Idaho counties and have a diagnosis on the autism spectrum to be eligible to apply for grant funding.

Grant amount requested: $_____

NEED: In your own words, please explain the need for which the grant is sought:

_____

_____

_____

_____

_____

PLAN: Please explain the anticipated uses of the grant funds, including specific goods or services to be purchased, vendor or providers of the goods or services, and the anticipated way in which the grant funds will address the above-referenced need:

_____

_____

_____

_____

_____

AUTISM CONNECTION: Please explain the connection between autism or ASD and the need for which the grant is sought:

_____

_____

_____

_____

_____

Documentation Justifying the Request (include letter of recommendation from physician, speech language pathologist or occupational therapist and/or other documentation for this grant):

Describe Other Current and Past Treatments/Services:

_____

_____

_____

_____

Name of other agencies or services also contacted for funding. Please indicate which have been contacted and total amount requested or received (if any):

_____

_____

_____

_____

ADDITIONAL COMMENTS: Please provide any additional information you believe would assist the grant committee in its decision (provide separate sheet if necessary).

_____

_____

_____

_____

_____

_____

I certify that:

1. I have read and understand the guidelines of the PAS grant program;

2. the information contained in this application is true and correct to the best of my knowledge;

3. I agree to cooperate with the Board of Directors or its designate regarding this grant application and provide additional information required;

4. the grant guidelines are not contractual and the Board of Directors or its designate has sole discretion over the operation of the PAS grant program;

5. the funds received will be used as outlined in this application and not for any purpose that would jeopardize the 501(c)(3) status of the Panhandle Autism Society; and

6. I will provide a written report to the Board of Directors or its designate on the use of the funds received from the PAS individual grant program according to the grant requirements.

7. I understand that all applications and supporting documentation must be mailed to **Panhandle Autism Society at P. O. Box 3950, Coeur d'Alene, ID 83816 and postmarked no later than June 8th, 2018.**

_____ _____

Parent/Guardian signature Date

_____

Parent/Guardian printed name

The Panhandle Autism Society (PAS) does not discriminate on the basis of race, color, creed, religion, national origin, gender, sexual orientation, or age in any of its operations or programming.