ALLAY AUTISM SCHOLARSHIP APPLICATION

Who may apply?

A family applying for this scholarship must:

- Currently live in the County of San Diego in the State of California.
- Demonstrate the need for funds to help a child who is affected by autism.
- Be applying for a child under the age of 24.

What is the amount of the scholarship?

The scholarships to be awarded will provide up to $2,000 for payment of therapeutic services or equipment payable directly to the clinic where your child has received the services, licensed therapist or business or the equipment vending company that supplies the equipment.

What is the process?

- Complete & Submit Online Application.
- Applications are reviewed quarterly in the order in which they are received.
- All applicants will be notified via email the status of their application within 90 days.
- Families must be back in contact with a representative of Be Involved * Act Now * Cure Autism, Inc. within 2 weeks of notification of scholarship.
- All scholarship monies must be utilized for purposes stated within one year from notification date.
- Applications that are incomplete will not be considered.
- All information included in this application is confidential and for use only during consideration for B.I.A.N.C.A. scholarship award process. Keep a copy for your records.
- **If you require any assistance, or have any questions, email us at info@biancanpo.org or call Allison at 858.952.4289.**

Guidelines

- Allay Autism Scholarships will fund effective treatments and services to treat autism spectrum disorders and cannot fund living expenses, travel, utilities or clothing.
- The scholarship may NOT be used to pay insurance premiums.
- Funds may not be used for previous outstanding balances and must be for services past scholarship award date.
- Applications will only be accepted online. If you have a problem submitting application, please email us at info@biancanpo.org.

HIPAA NOTICE: The United States Congress has enacted the Health Insurance Portability and Accountability Act (HIPAA), which took effect April 14th, 2003. HIPAA was designed to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers. We are required by applicable federal and state law to maintain the privacy of your medical information.

Is a 501(c)(3) nonprofit organization, EIN 45-2813830, established to provide funds for physical, psychological and occupational therapy for autistic children in need and to support autism research and cures. For more information, visit us at www.biancanpo.org. All donations are tax-deductible to the extent allowable by the IRS.

2226 River Run Drive ✚ Suite 163 ✚ San Diego, CA 92108 - 5828 ✚ P: 4BIANCANP0 (424.262.2670) ✚ E: allison@biancanpo.org

PUBLICITY RELEASE FORM

Permission to Photograph/Use of Photograph

I give my consent for representatives of **Be Involved * Act Now * Cure Autism, Inc.** to use my child's name and/or picture for the purposes of community awareness, community acknowledgement and raising funds.

I give my consent for Be Involved * Act Now * Cure Autism, Inc. to contact television, radio and newspaper media to do stories about my child's scholarship for the purpose of increasing public awareness of their programs, goals and fundraising needs.

I understand that my willingness to allow my child's name and picture to be used for publicity may help to facilitate funds for children to follow. However, my refusal to participate in Be Involved * Act Now * Cure Autism, Inc.. publicity campaign will not determine whether Be Involved * Act Now * Cure Autism, Inc. decides to approve or disapprove this scholarship request.

I understand that this publicity agreement in no way affects my child's right to participate in the publicity campaign for any other organization.

The undersigned, aware that videos and photographs may be taken during fulfillment of the scholarship by the parents/guardians or by representatives of Be Involved * Act Now * Cure Autism, Inc. or by news stations and press, individual and on behalf of the family members listed below, consents to be photographed and filmed without compensation. Photographs may be used for new articles, press releases, newsletters and/or on the website of Be Involved * Act Now * Cure Autism, Inc.

Please check one:

D I DO give my permission

D I do NOT give my permission

Child's Name (Please Print): _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

BE INVOLVED • ACT NOW • CURE AUTISM

B I A N C A

ALLAY AUTISM SCHOLARSHIP APPLICATION

CONTACT INFORMATION			
Full Name of Person Submitting Application:		Relationship to Child:	
Cell:		Email:	
CHILD / APPLICANT INFORMATION			
Last Name:	First Name::	Middle Name:	Date of Birth:
Street Address:		Apartment/Unit #:	
City:	State:	County:	Zip:
School Attending:			
Child's Medical History, including age when diagnosed with ASD and functional status:			
Who Does The Child Live With: ☐ Biological Parents ☐ Grandparents ☐ Adoptive Parents ☐ Foster Parents ☐ Other: _____			
Who Else Lives In Home:			
On a day-to-day basis, who is child's primary caregiver? (**DO NOT** list primary doctor):			
FAMILY INFORMATION			
Mother's Full Name:		Date of Birth:	
Cell:		Email:	
Employer:		Salary:	
Father's Full Name:		Date of Birth:	
Cell:		Email:	
Employer:		Salary:	
SIBLINGS			
Name:	DOB:	School Attending:	
Does this child have autism or any other medical issues:? ☐ YES: ☐ NO If yes, please explain:			
Name:	DOB:	School Attending:	
Does this child have autism or any other medical issues:? ☐ YES: ☐ NO If yes, please explain:			
Name:	DOB:	School Attending:	
Does this child have autism or any other medical issues:? ☐ YES: ☐ NO If yes, please explain:			
Name:	DOB:	School Attending:	
Does this child have autism or any other medical issues:? ☐ YES: ☐ NO If yes, please explain:			
INCOME			
What was your **COMBINED ANNUAL** household income last year? **$**			
Signature:		Date:	

B.I.A.N.C.A. USE ONLY: DOB: _____ DX: _____ Applicant#: _____

BE INVOLVED • ACT NOW • CURE AUTISM

B I A N C A

ALLAY AUTISM SCHOLARSHIP APPLICATION

THERAPY

What Are Your Family's Average Out-of-Pocket Monthly Medical Bills (Co-Pays, Medications, etc.) $ _____

SERVICES CURRENTLY RECEIVING	FREQUENCY / WEEK	YOUR OUT OF POCKET COST/SESSION	DOES INSURANCE COVER THIS SERVICE?	DOES MEDICAID COVER THIS SERVICE?
ABA Therapy:		$	☐ YES ☐ NO	☐ YES ☐ NO
Occupational Therapy:		$	☐ YES ☐ NO	☐ YES ☐ NO
Psychological Therapy:		$	☐ YES ☐ NO	☐ YES ☐ NO
Speech Therapy		$	☐ YES ☐ NO	☐ YES ☐ NO
Physical Therapy		$	☐ YES ☐ NO	☐ YES ☐ NO
Aquatic Therapy		$	☐ YES ☐ NO	☐ YES ☐ NO
Equestrian Therapy		$	☐ YES ☐ NO	☐ YES ☐ NO
Music Therapy		$	☐ YES ☐ NO	☐ YES ☐ NO
Other: _____		$	☐ YES ☐ NO	☐ YES ☐ NO
Other:_____		$	☐ YES ☐ NO	☐ YES ☐ NO

How would you allocate the donated funds you're requesting for your child? Please include business, contact info & reason for choosing for any and all possible services you wish to allocate the scholarship award of up to $2,000:

What are your biggest concerns re: the care your child is currently receiving verse the care you want your child to receive? Are there any resources unavailable to you in San Diego that could address your concerns …the sky is the limit:

How did you hear about B.I.A.N.C.A.:

Is there anything else you want us to know:

B.I.A.N.C.A. USE ONLY: DOB: _____ DX:_____ Applicant#: _____