

# GRANT APPLICATION

## NATIONAL AUTISM ASSOCIATION ALL ACCESS COMPUTER PROGRAM

**P.O BOX 1547  
MARION, SC 29407  
Tel: (877) 622-2884**

The NAA All Access Computer Project will provide computers to families who are unable to afford it. **Single parents have priority. Child's diagnosis must be confirmed.**

NAME OF CHILD:

\_\_\_\_\_

LAST	FIRST	MIDDLE
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AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MOTHER:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

STREET/CITY/ZIP:

\_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER ADDRESS:

\_\_\_\_\_

IMMEDIATE SUPERVISOR:

\_\_\_\_\_

FATHER:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

STREET/CITY/ZIP:

\_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER ADDRESS:

\_\_\_\_\_

IMMEDIATE SUPERVISOR:

\_\_\_\_\_

NUMBER & AGES OF OTHER DEPENDENT CHILDREN: \_\_\_\_\_

DIAGNOSIS OF DISABILITY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DOCTOR INVOLVED IN CHILD'S TREATMENT:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAMES OF OTHER AGENCIES OR SERVICES ALSO CONTACTED FOR FUNDING:

Please indicate which have been contacted and total amount requested or received (if any).

SUPPLEMENTAL SECURITY INCOME (SSI) \_\_\_\_\_

OTHERS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DOCTOR'S LETTER: We must have a letter from your child's physician which states the child's diagnosis.**

In signing this application, I agree to allow the child and/or parents to be named and/or photographed, and used in promotion of National Autism Association's fundraising activities.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

This application cannot be considered until this form is completed, signed, and all supporting documents (including doctor's letter) are received.

# CONFIDENTIAL:

(This information for use by NAA only.)

## Personal Statement of Income and Financial Status of Both Parents or Guardians

### ASSETS

CHECKING ACCT:

\$ \_\_\_\_\_

SAVINGS ACCT:

\$ \_\_\_\_\_

REAL ESTATE:

\$ \_\_\_\_\_

HOME:

\$ \_\_\_\_\_

AUTOMOBILES:

\$ \_\_\_\_\_

PERSONAL PROPERTY:

\$ \_\_\_\_\_

OTHER AMOUNT:

\$ \_\_\_\_\_

OTHER AMOUNT:

\$ \_\_\_\_\_

OTHER AMOUNT:

\$ \_\_\_\_\_

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**TOTAL ASSETS:**

\$ \_\_\_\_\_

### LIABILITIES (MONTHLY BILLS DUE)

HOUSE PAYMENT/RENT:

\$ \_\_\_\_\_

OTHER BILLS/LOANS:

\$ \_\_\_\_\_

UTILITIES:

\$ \_\_\_\_\_

INSURANCE:

\$ \_\_\_\_\_

AUTOMOBILES:

\$ \_\_\_\_\_

**MEDICAL BILLS DUE:**

\$ \_\_\_\_\_

PHYSICIAN/AGENCY:

\$ \_\_\_\_\_

PHYSICIAN/AGENCY:

\$ \_\_\_\_\_

PHYSICIAN/AGENCY:

\$ \_\_\_\_\_

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**TOTAL LIABILITIES**

\$ \_\_\_\_\_

### COMBINED SOURCES OF INCOME:

Previous year's IRS return must be provided.

**INCOME TYPE**

**MONTHLY**

**ANNUAL**

SALARY:

\$ \_\_\_\_\_

\$ \_\_\_\_\_

BONUSES + COMMISSIONS:

\$ \_\_\_\_\_

\$ \_\_\_\_\_

ALIMONY/CHILD SUPPORT:

\$ \_\_\_\_\_

\$ \_\_\_\_\_

REAL ESTATE INCOME:

\$ \_\_\_\_\_

\$ \_\_\_\_\_

ALL OTHER INCOME:

\$ \_\_\_\_\_

\$ \_\_\_\_\_

**TOTAL INCOME:**

\$ \_\_\_\_\_

\$ \_\_\_\_\_

(ALL OTHER INCOME is including Grants, Social Security, CRS, Medicaid, etc.)

**The above information is freely given to expedite this grant request.**

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Mail completed application to:**

*National Autism Association  
c/o Leslie Davidson  
14 Woodside Avenue  
Oneonta, NY 13820*