APPLICATION FOR FINANCIAL ASSISTANCE
VAST Foundation
P.O. Box 1030
Pleasanton, CA 94566

Please completely review the **VAST Family Scholarship Program Guidelines BEFORE** completing this application.

This program is intended ONLY for parents in DIRE financial need.

APPLICANT

Mother/Father's
Name:____

Home Address/City/Zip:____

Home Phone:_________________________ Business Phone: ______________________

E-mail Address:____

CHILD INFORMATION

Name: ______________________________ Age:______ Date of Birth: ____________

Do you have MORE THAN ONE child with autism spectrum disorder living with you?
___Yes ___No If yes, how many?
Please provide their ages and diagnosis.

MARITAL STATUS: Are you married? __Yes ___No Are you a single parent? __Yes __No

INSURANCE
Do you have health insurance for your family? ___Yes Type:__________________ ___No

SERVICES
What is the name of your school district: ____
Do you receive any services from your school district? ___Yes ___No
From your Regional Center or Early Start Program ____Yes ___No
Have you received assistance from other agencies/organizations? If so, please note the amount, for what and when. ___Yes ___No

____

Have you recently applied to other agencies or services for funding __Yes ___No
If so, please indicate which and total amount requested.
____

PROPOSAL SUMMARY – (We have provided a "SAMPLE PROPOSAL SUMMARY" for reference purposes as a separate page of the application).

On separate sheets of paper, please provide the following:

1. Please describe what is being requested and why. Be specific. For example: First visit to a *Defeat Autism Now!* doctor and costs for labs.

2. Please outline all of the current therapies and treatments your child is receiving. Are you currently implementing a special diet? If not, would you be willing to do so as a requirement of seeing an autism practitioner/doctor? Are you implementing biomedical intervention? If so, what have you tried so far? Are you working with an autism practitioner/doctor? If so, who?

3. Please include a breakdown of the costs – doctor visits, lab costs, supplements. (This can include estimates from doctor for initial appointments, lab work and supplements. The doctor's office should be able to help you with this).

4. Please make it clear to the committee where you are on your biomedical journey and explain what your goals would be for an autism practitioner/doctor visit.

5. Are there other doctors involved in child's treatment? Please provide their names and contact information.

   Name: ______________________________________ Phone: __________________________

   Address:
   ____

   Name: ______________________________________ Phone: __________________________

   Address:
   ____

6. Please include contact information for the practitioner you have chosen to use should the scholarship be funded.

   Name: ____Phone: ______________________

   Address: ____

   Phone/Fax____

Personal Statement of Income and Expenses of Custodial Parents or Guardians

Combined sources of income

INCOME TYPE	MONTHLY	ANNUAL
Salary:	$____________	$____________
Bonuses and Commissions:	$____________	$____________
Alimony/Child Support:	$____________	$____________
Real Estate Income:	$____________	$____________
All Other Income*:	$____________	$____________
TOTAL INCOME:	**$____________**	**$____________**

(*Please specify the sources of "ALL OTHER INCOME" including Grants, Social Security, CRS, Medicaid, etc.)

Source	Amount	Frequency of payment
____________________	**$____________**	____________________
____________________	**$____________**	____________________
____________________	**$____________**	____________________

EXPENSES

Expenses	MONTHLY	ANNUAL
House payment/rent:	$____________	$____________
Utilities:	$____________	$____________
Home/Auto/:Life Insurance:	$____________	$____________
Auto Payment/Fuel/Repairs:	$____________	$____________
Medical Insurance/Bills:	$____________	$____________
		$____________
Other Bills/Loans/Cr. Cards		
TOTAL EXPENSES:	**$____________**	

I/We certify that the information on this form is true and complete to the best of my/our knowledge.

Agreement: I/We agree if approved for funding that we will follow the recommendations and guidelines recommended by the treatment facility. _________(initial).

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

APPLICANT SIGNATURE: ____

____

DATE:___________

Mail completed application and other required documentation (see Checklist), to:

The VAST Foundation
P.O. Box 1030
Pleasanton, CA 94566

This application cannot be considered until this form is completed, signed, and all supporting documents (including doctor's letter) are received. The information included in this application is confidential and for VAST Foundation use only. Please keep a copy for your records.

VAST Foundation
Family Scholarship Program Application

<u>CHECKLIST</u>

APPLICATION IS NOT COMPLETE WITHOUT THE FOLLOWING:

- ❑ **Proof of diagnosis**
- ❑ **Copy of current year-to-date pay stub for all household wage earners**
- ❑ **Copy of first two pages of most recent tax return**
- ❑ **Completed summary of previous treatments and explanation of why you chose the doctor you are requesting funding through**
- ❑ **Contact information for doctor**
- ❑ **Cost breakdown – can include estimates from doctor for lab work and supplements. The doctor's office should be able to help you with this.**
- ❑ **Explanation of goals for your child's visit to an autism practitioner/doctor.**

SAMPLE PROPOSAL SUMMARY

I would like to apply to VAST FOUNDATION to cover an initial visit to an autism practitioner/doctor and the cost of labs for my son James. My HMO doctor has no idea how to interpret the testing we have done and my HMO will not pay for me to see an autism practitioner/doctor.

Here is the cost break down for the first visit and for the labs and supplements (copies of estimate from Dr. D. Doctor):

Doctor visit: $450
Follow-up visit: $250
Labs: $500
Supplements: 300

Total requested: $1500

At this point I need a doctor's guidance to see what other issues can be treated biomedically. I have implemented a Gluten Free Casein free diet for my son with great success. I have tried to add in some vitamins, but without lab work, I am not sure what we should be giving our son. Also, we have never done a chelation challenge nor have we had a comprehensive stool test to determine if yeast may be an issue.

I have read <u>Children with Starving Brains</u> and <u>Changing the Course of Autism</u> and realize that there are many more treatments that I can explore, but only with the help of a qualified doctor. Since the diet has been so helpful for my son, it seems logical that there are other issues that could be helped with proper supplementation and possibly chelation. In interviewing Dr. D. Doctor I feel that he will make an excellent partner in helping figure out what treatments will be most effective for my James. I contacted Dr. D. Doctor and have confirmed that he will accept a third-party check should our grant be successful. Thank you for your consideration and please let me know if you need any further information from me.

All information submitted to VAST shall remain **confidential**. Please note that, pursuant to California and federal law requirements, VAST reserves the right to follow up to ensure any approved grant was actually used for its intended purpose.

I certify that the information on this form is true and complete to the best of my knowledge.

____

Applicant Signature **Date**

Please include the following with this application and mail to
VAST Families in Scholarship Program, P.O. Box 1030, Pleasanton, CA 94566