

Parker's Purpose

2011 Grant Application

This grant application is to support biomedical interventions to help children with Autism Spectrum Disorders. Children with the diagnosis of Autism, Asperger's Syndrome, and Pervasive Developmental Delay will be considered. This grant is intended only for biomedical treatments provided at Dr. Cheryl Leuthaeuser's office in Richfield, OH. Biomedical treatments at her office may include: dietary and nutritional counseling, Osteopathic manipulation, acupuncture, nutritional supplements, hyperbaric oxygen therapy (HBOT).

Application checklist:

1. Completed application form
2. Previous year's Federal return
3. Letter of intentions/requests

Application deadline:

Applications must be postmarked by May 1, 2011

Frequently Asked Questions

Q; How much money can I request?

A: The maximum we can award per child is \$1,250.00, but most grants are \$500.00 or \$1,000.00 so more children may be served.

Q: How do I apply for assistance from Parker’s Progress?

A: First, complete the grant application. The application has 3 parts: a completed application form, proof of your child’s diagnosis, a letter from the parent how this grant will affect his/her child and you must provide a copy of your most recent tax return.

Q: Are the funds paid directly to families?

A: At no time are funds transferred to families. All grants awarded are paid directly to the physician to pay for office visits, supplements, testing and treatment.

Q: I’ve sent my application in. How long until I know if my application has been approved?

A: Once we have received all the components of the application, your application will be reviewed by the staff of Parker’s Progress. No awards will exceed \$1,250.00. ONLY APPROVED GRANT RECIPIENTS WILL BE CONTACTED BY PARKER’S PROGRESS.

Q: If I have health insurance, can I still apply?

A: Yes

APPLICATION FORM

CHILD’S NAME _____ AGE _____

CHILD’S DATE OF BIRTH _____

MOTHER

MOTHER'S NAME _____ TELEPHONE _____

MARITAL STATUS _____

ADDRESS _____

EMPLOYER _____ TELEPHONE _____

EMPLOYER ADDRESS _____

FATHER

FATHER'S NAME _____ TELEPHONE _____

MARITAL STATUS _____

ADDRESS _____

EMPLOYER _____ TELEPHONE _____

EMPLOYER ADDRESS _____

NUMBER AND AGES OF OTHER DEPENDENT CHILDREN

DIAGNOSIS OF DISABILITY

OUTLINE OF FUNDING REQUESTED (LIMIT-ONE TIME GRANT \$1,250 MAXIMUM)

DOCTOR'S INVOLVED IN YOUR CHILD'S TREATMENT

NAME _____ PHONE _____

ADDRESS _____

NAME _____ PHONE _____

ADDRESS _____

NAME OF OTHER AGENCIES OR SERVICES ALSO CONTACTED FOR FUNDING

SUPPLEMENTAL SERCURITY INCOME (SSI) _____

Personal Statement of income/financial status of custodial parents or guardians:

ASSETS

LIABILITIES

Checking account	\$_____	Monthly housing payment	\$_____
Savings account	\$_____	Other monthly bills/loans	\$_____
Real Estate	\$_____	Monthly utilities	\$_____
Home value	\$_____	Monthly Insurance	\$_____
Automobiles	\$_____	Monthly automobile expenses	\$_____
Personal property	\$_____	Medical bills due	\$_____
Other Assets	\$_____	Physician/Agency	\$_____
Total Assets:	\$_____	Total Liabilities:	\$_____

Combined sources of income:

Previous year's Federal Tax return or other proof of income must be attached.

<u>INCOME TYPE</u>	<u>MONTHLY</u>	<u>ANNUAL</u>
Salary	\$_____	\$_____
Bonuses/Commissions	\$_____	\$_____
Alimony/Child support	\$_____	\$_____
Real Estate income	\$_____	\$_____

