TAG
Tri-County Autism Group
Grant Program Notice

TAG is a nonprofit 501(c)(3) organization whose mission is to raise awareness and provide treatment services and support to families to help their children with autism achieve their full potential. Our goal is to introduce and help facilitate early and on-going treatment by providing the necessary resources (including referrals, funding and guidance) to individuals with autism and their families. TAG is proud to offer a grant program for assessments, treatments, and life supports that may not otherwise be covered privately or by other third-party funding sources such as school districts, county programs, insurance, and/or other grant making entities.

Applicants who meet the following grant program criteria and complete the Grant Application will be considered for TAG grants. Since in most cases, the applicant's parent or guardian will be completing the application, it is understood that the applicant will be the individual receiving the benefits of the grants.

Grant Making Philosophy

TAG grants are designed to provide access to individuals and families affected by Autism Spectrum Disorders. **Grant payments will be made directly to pre-approved treatment providers, assessors or materials vendors.**

Amount Requested

Grants will be allocated based on annual fundraising activities. The Board of Directors will determine the number and amounts of each grant at the beginning of each term. Requests for endowments or multi-year grants will not be accepted. Each application is kept in our system for two consecutive grant cycles after which the applicant must re-apply.

- Applicants must demonstrate financial need by providing the following:
  - Proof of Household Income
  - # of Dependants / # of Dependants with Autism Spectrum Disorders
  - Information about access to third-party funding sources
- The following must be sent to TAG in order to be eligible for grants:
  - Completed, signed and dated Grant Application
  - Verification of Diagnosis (please provide documentation as proof of diagnosis)
  - Documentation from provider of your requests (pg. 4) stating costs of the requested item
  - 200 Word Description of current family situation
- Grant Applications must be postmarked no later than the deadline date specified
- Faxed or Emailed Grant Applications will be accepted
- Should your grant be funded, you will be asked to complete two short questionnaires regarding your experiences as a result of the funding you received. We also encourage families to share photos and stories.
- Grant Applications must be mailed to:

TAG
Attn: Grant Committee
P.O. Box 597
Valley Springs, California 95252
You Can Also Email or Fax Us
info@tricountyautismgroup.com / (209) 772-2105

Applicant receiving a grant agrees to repay the grant if any services paid for with the grant are reimbursed by another funding source, such as, a school district or insurance company.

The grant deadline is posted below. Incomplete Grant Applications will not be considered.

Please Allow 6 - 8 Weeks For Response.

TAG - Grant Application

Please type or print clearly in the form below.

Today's Date: _____

How did you hear about TAG Grant Program? (please list name if referred by a person)

Have you previously applied for an TAG grant? No Yes, Date _____ Outcome _____

General Information

Applicant's Name (Child affected by Autism Spectrum):		Applicant's Date of Birth:
Applicant's Current Age:		Applicant's Gender: ❑ FEMALE ❑ MALE
Street Address:		
City:	State:	Zip Code:
1) Guardian #1 Name:		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address:	
2) Guardian #2 Name:		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address:	

❑ Check this box if at least one parent or guardian of the applicant serves or has served in the United States Armed Forces. Please indicate date and branch of service:

Dependant/Sibling Information

			Autism Spectrum Disorder Diagnosis
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO

History

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the TAG grant review process. I give TAG permission to verify treatment information by contacting the treatment vendors directly. This authorization shall be valid for one year unless otherwise stated. I understand that I may revoke this authorization in writing at any time. _____

Signature/Date:

Current Diagnosis:	Date of Diagnosis:
Diagnosed by: (Name of Physician)	
Name of Institution where Diagnosed:	Telephone Number:

Street Address:	City:	State:	Zip Code:

Treatment

Type of Treatment	**Treatment History** (please check one)	**Frequency** (example: 2hrs per week)	**Provider of Services**
Speech Therapy	❑ Current ❑ Past ❑ Not applicable		
Occupational Therapy	❑ Current ❑ Past ❑ Not applicable		
Physical Therapy	❑ Current ❑ Past ❑ Not applicable		
Applied Behavior Analysis	❑ Current ❑ Past ❑ Not applicable		
Special Diets	❑ Current ❑ Past ❑ Not applicable		
Biomedical Testing	❑ Current ❑ Past ❑ Not applicable		
Biomedical Intervention	❑ Current ❑ Past ❑ Not applicable		
Social Skills Groups	❑ Current ❑ Past ❑ Not applicable		
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable		
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable		
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable		
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable		
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable		

Grant Funds Request

Check all that apply, complete requested information and include copies of supportive documentation, such as, letters of support from service providers, service/intervention descriptions, treatment cost sheets, provider brochures, receipts etc.
Supportive documentation must include cost of treatment/items.

❑ Direct Treatment

Total Cost of Treatment: $	Grant Amount Requested for Treatment: $	Supportive Documentation Attached: ❑ Yes ❑ No (If "No" application will not be considered)

Grant Request is for the following Service/Intervention(s):

Provider Name:	Provider Contact Telephone Number:

Street Address:

City:	State:	Zip Code:

Describe details: (Include who will provide treatment, frequency and duration of treatment, etc.)

❑ Assessments or Testing

Total Cost of Assessment/testing: $	Grant Amount Requested for Assessment/Test(s): $	Supportive Documentation Attached: ❑ Yes ❑ No (If "No" application will not be considered)

Grant Request is for the following Service/Intervention(s):

Provider Name:	Provider Contact Telephone Number:

Street Address:

City:	State:	Zip Code:

Describe details: (Include who will provide testing at what frequency and purpose)

❑ Materials

Total Cost of Assessment(s): $	Grant Amount Requested for Assessment(s): $

Grant Request is for the following Service/Intervention(s):

Provider Name:	Provider Contact Telephone Number:

Street Address:

City:	State:	Zip Code:

Describe details: (Include reason materials required)

Financial Information

Guardian #1 Current Monthly Gross Income:	$
Guardian #2 Current Monthly Gross Income:	$
Other Sources of Income: Source:	
Monthly Gross Amount:	$
Source:	
Monthly Gross Amount:	$

Funding Sources (including other grants or scholarship awards)

Check all funding sources that apply and complete the requested information.

❑ **Private/Health Insurance**

Insurance Company:	Contact Person:	Telephone Number:
Treatments Covered:		

❑ **Regional Center**

Regional Center:	Contact Person:	Telephone Number:
Services Provided:		

❑ **School District**

School District:	Contact Person:	Telephone Number:
Services Provided:		

❑ **County**

County:	Contact Person:	Telephone Number:
Services Provided:		

❑ **Other**

Describe:	Contact Person:	Telephone Number:
Services Provided:		

❑ **Other**

Describe:	Contact Person:	Telephone Number:
Services Provided:		

Description of Family Situation

Please describe in 200 words or less your family situation. You may use the space below or attach a separate sheet. If you attach a separate sheet please check this box. ❑

Letters of Recommendation (optional)

Please attach no more than two letters of recommendation from service providers, case workers or other individuals familiar with your family's situation. Letters of recommendation are optional and should be no more than one page in length.

FOR OFFICE USE ONLY

Application Postmarked by Deadline	❑ YES	❑ NO
Diagnosis Verification	❑ YES	❑ NO
Treatment Verification	❑ YES	❑ NO
Support Documents to Verify Costs	❑ YES	❑ NO
Assessment Verification	❑ YES	❑ NO
200 Word Description of Situation Submitted	❑ YES	❑ NO

TAG Board Review

❑ Approved ❑ Declined - Reason: _____

Amount Approved:	Date Applicant Notified:	Board Approval Signature:	Date:
$			

Comments/Notes:

RELEASE AND AUTHORIZATION FOR USE OF IMAGE

I hereby release TAG to use photographs, reproductions, video tapes, recordings or endorsements of/by me and/or my child for publicity, fundraising or any other purpose.

Name of Parent: _____

Description of Use: _____

I hereby grant TAG the following rights:

1. To use my / my child's first name (you may ask that names are withheld – see below), photograph, picture, portrait, likeness, and voice in connection with its educational materials or publicity or for any other legitimate reason
2. To use, reproduce, publish, exhibit, distribute, and transmit my / my child's image individually or in conjunction with other images or printed matter in the production of brochures, motion pictures, television tape, sound recordings, still photography, CD-ROM, and other media
3. To record, reproduce, and amplify my image and all sound effects produced

I hereby release and discharge TAG from any and all claims, actions and demands arising out of or in connection with the use of said image, including, without limitation, any and all claims for invasion of privacy and libel. I hereby waive the right to inspect or approve my / my child's image or any finished materials that incorporate my image. I understand and agree that I will receive no compensation, now or in the future, in connection with the use of my / my child's image.

I represent that I have read the preceding and completely understand the contents.

Authorizer's Name: _____

Child's Name: _____

Signature of Parent or Guardian: _____

Relationship to Client: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Authorized Use of Name (please circle one): Yes No