



## **TACA Hawaii and Hawaii Autism Foundation Family Scholarship Program Application**

Summary: This application is for families who meet the eligibility criteria and wish to pursue Biomedical Treatment. Please present a complete proposal requesting funding, including cost breakdown.

Applicant Name (Last, First) \_\_\_\_\_

Parent or primary caregiver \_\_\_\_\_

Home Address (Street, City, State, Zip) \_\_\_\_\_

Home Telephone \_\_\_\_\_

Business/Other Telephone \_\_\_\_\_

E-mail Address \_\_\_\_\_

### COMPLETE THE FOLLOWING INFORMATION FOR CHILDREN LIVING WITH YOU:

Please list child's first name \_\_\_\_\_

Birth date \_\_\_\_\_ diagnosis if any \_\_\_\_\_

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Birth date \_\_\_\_\_ diagnosis if any \_\_\_\_\_  
(write on back if more than 3 children)

MARITAL STATUS: Are you married? ☐ Yes ☐ No

If you are a single parent, do you receive monthly child support? ☐ Yes ☐ No

If yes, how much \$ \_\_\_\_\_

### INCOME:

What is your combined monthly household employment income? \_\_\_\_\_

Do you receive state or federal assistance (SSI/SDI)? ☐ Yes ☐ No If yes, how much per month \$ \_\_\_\_\_

### INSURANCE:

Do you have private health insurance for your child ☐ Yes Type: \_\_\_\_\_ ☐ No

Do you have state paid insurance (i.e. Healthy Kids or Medicaid/MediCal)? ☐ Yes Type: \_\_\_\_\_ ☐ No

### SERVICES:

If your child is 0-3 is your child in Early Start/Early Intervention? ☐ Yes ☐ No

If your child is over age 3 what is their current school placement? Public/Private/In-Home Program \_\_\_\_\_

### CURRENT FAMILY DEBT:

HOUSING: ☐ Own Home ☐ Rent ☐ Temporary Housing Monthly housing commitment \$ \_\_\_\_\_

Do you have a 2<sup>nd</sup> mortgage on your home: ☐ Yes ☐ No Monthly housing commitment 2<sup>nd</sup> Mortgage \$ \_\_\_\_\_

Credit card debt:

Number of credit cards your family has: \_\_\_\_\_ Current Balance \$ \_\_\_\_\_ Monthly Minimum Payments \_\_\_\_\_

TACA MEMBERSHIP: Date of first TACA meeting attended: \_\_\_\_\_ or Date you joined TACA on the web: \_\_\_\_\_  
(Required: Must be a TACA member for a minimum of 6 months prior to applying for a MAPS/DAN Doctor Scholarship)

NAME OF PARENT MENTOR: \_\_\_\_\_  
(Required: Must have a Parent Mentor for at least 2 months prior to applying for a MAPS/DAN Doctor Scholarship)

Date You Joined TACA-USA Yahoo Group: \_\_\_\_\_ (Required)

TACA ASSISTANCE:

Have you ever received assistance from TACA before? If so, please note the amount, for what and when. ☐ Yes ☐ No

Type of services awarded previously: \_\_\_\_\_

**Proposal SUMMARY:**

**ON SEPARATE SHEETS OF PAPER, PLEASE PROVIDE THE FOLLOWING:**

Please describe what is being requested and why. Be specific. For example: First visit to a MAPS/DAN doctor and cost for labs. TACA has provided a sample for your review. For questions, please contact the TACA Family Scholarship Program Coordinator at [Maira.Giammatteo@tacanow.org](mailto:Maira.Giammatteo@tacanow.org) or by clicking the following link: <http://www.tacanow.org/contact/family-scholarship-program/>

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 a MAPS/DAN Doctor. Are you implementing biomedical intervention? If so, what have you tried so far? Are you working with a MAPS/DAN Doctor? If so, who?

Please include a breakdown of the costs – i.e. MAPS/DAN doctor visit, lab costs, etc. **(Maximum Request \$1500)**

Please make sure you have read ("[Try before you Apply](#)") document on the TACA website that discusses what items will likely NOT be funded by a Hawaii Autism Foundation and TACA Hawaii Family Scholarship.

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

Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Please make it clear to the committee where you are on your biomedical journey and explain what your goals would be for a MAPS/DAN Doctor visit.

Please share with the committee how you plan to fund ongoing treatment, since the TACA Family Scholarship Program is a one-time only grant.

Have you attended any of the following: ARI, USAAA or Autism One conferences or a TACA Autism Journey Seminar or TACA Real Help Now Conference? If so, which cities and years did you attend?

All information submitted to TACA shall remain **confidential**. Please note that, pursuant to California and federal law requirements, TACA 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

## **CHECKLIST**

### **APPLICATION IS NOT COMPLETE WITHOUT THE FOLLOWING:**

- ☐ Proof of diagnosis. (Need not be the entire evaluation, just the page with the child's name that confirms diagnosis.)
- ☐ Copy of your most recent Tax Return.
- ☐ Copy of a utility bill to prove residency in Hawaii
- ☐ Date you became a TACA Member.
- ☐ Name, and date you started with, your TACA Parent Mentor.
- ☐ Completed summary of previous treatments and explanation of why you chose the MAPS/DAN doctor you are requesting funding for.
- ☐ Contact information for MAPS/DAN doctor.
- ☐ Cost breakdown – include estimates from MAPS/DAN doctor.
- ☐ Explanation of Goals for your child's visit to an MAPS/DAN Doctor.
- ☐ Explanation of how you plan to fund ongoing treatment, since the Hawaii Autism Foundation and TACA Hawaii Family Scholarship Program is a one-time only grant.

**Please mail completed application to: TACA Family Scholarship Program  
2222 Martin Street, Suite 140  
Irvine, CA 92612**