

AUTISM THERAPY SUPPORT APPLICATION

APPLICATION FOR FINANCIAL ASSISTANCE FOR UP TO \$500 FOR ONE YEAR OF THERAPY SUPPORT

Child Name DOB

Age Sex ☐ Female ☐ Male Nationality

Parent Name Phone

Address

City/State

Zipcode

Email

Marital Status

☐ Single

☐ Married

☐ Others

Recommended By

☐ Pediatrician/
Doctor

☐ School

☐ Others

School District

Has your child been tested for autism prior?

☐ Yes

☐ No

Does your child have a formal diagnosis of autism?

☐ Yes

☐ No

Does your child currently receive therapy?

☐ Yes

☐ No

If YES, select all that apply.

☐ Behavior Therapy

☐ Speech-Language Therapy

☐ Play-based Therapy

☐ Physical Therapy

☐ Occupational Therapy

Name of therapy facility?

EMPLOYMENT STATUS

☐ Unemployed

☐ Employed

☐ Self Employed

Please provide 2 most recent check stubs.