BARBRIDGE FOUNDATION

AUTISM DIAGNOSITC APPLICATION

APPLICATION FOR FINANCIAL ASSISTANCE FOR INIATIAL AUTISM DIAGNOSITIC AND UP TO $500 FOR 6 MONTHS 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

EMPLOYMENT STATUS

☐ Unemployed ☐ Employed ☐ Self Employed

Please provide 2 most recent check stubs.