



Carlos Vieira Foundation Direct Help Application

HELPING FAMILIES LIVING WITH AUTISM

The Direct Help Grant Program is offered through the Foundation to provide services, medical necessities, and educational tools to families affected by autism who live in Central California.

A family can apply once per calendar year per child with autism. Please note that the **deadline for each calendar year is December 1st**. If a **completed application** (with all supporting documentation) is not received by this deadline, it will roll into the following year. There is a **limit of \$500 per grant**. Families must complete the application, provide all required supporting documentation, and the child must meet the three following requirements to be considered eligible:

1. Under the age of 18.
2. Resides within one of the following 21 counties: Merced, Glenn, Stanislaus, Butte, Madera, Colusa, Mariposa, El Dorado, Tuolumne, Sutter, San Joaquin, Yuba, Fresno, Yolo, Sacramento, Placer, Shasta, Kings, Tehama, Tulare, or Kern.
3. Diagnosed with an autism spectrum disorder.

Please read the grant program Frequently Asked Questions and ensure that the following check list is completed prior to applying.

Check List:

- Completed application** with current address and parent/guardian signatures
- Full diagnostic report of autism** from a developmental pediatrician, child neurologists, Regional Center psychologist, or private psychologist/psychiatrist (school IEPs will not be accepted as a diagnosis of autism)
- The most recent **IRS tax return/s** for both parents/guardians *with your child listed as a dependent*. If you do not file taxes due to Social Security, you must provide your award letter.
- A recommendation letter** from a Physician, Speech Therapist, Behavioral Therapist, or Licensed Psychologist that states how the requested item(s) will directly aid your child with his/her autism. This is only required if you are requesting an item other than tuition for a specific class for autism, supplements/medication, medical evaluations, learning materials, testing, or therapies.
- Electronic Device Form**. This is only required if you are requesting an electronic device (i.e. computer, iPad, etc.).
- Please keep a copy for your records

All of the check list items above must be submitted with the application for it to be approved, unless otherwise noted.

Mail completed application to:

CARLOS VIEIRA FOUNDATION
 DIRECT HELP PROGRAM
 6079 Washington Blvd.
 Livingston, CA 95334



Or complete application online at:

www.carlosvieirafoundation.org/apply-now

For Questions, please email info@carlosvieirafoundation.org.



Carlos Vieira Foundation Grant Application FAQ's

Q: How do I apply for assistance from the Carlos Vieira Foundation for my child?

First, review the eligibility criteria. If you meet these, then you must complete a grant application. You must also submit supporting documentation including your child's diagnosis of autism and a copy of your most recent tax return for each parent/guardian. A recommendation letter from a medical professional and the electronic device form may also be required (refer to application check list).

Q: Why does the application require my social security number?

We require social security numbers to award grants, because you will be engaging in a transaction that requires notification to the Internal Revenue Service.

Q: Can I fax or email my grant application?

No, all applications must be submitted through the website or sent by postal mail.

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

Approved applications will normally be given out within 60 days of receiving an application. Applicants will be notified by mail or email if applications are incomplete and additional information is required.

Q: How can I confirm that my application has been received?

You will receive a confirmation email when you submit your online application. When you mail your application, request delivery confirmation or a return receipt from the post office. **We cannot accept phone calls asking if applications have been received.**

Q: Is there a maximum amount I can request?

The maximum amount we can award per child is \$500 per year.

Q: Are grant funds paid directly to families?

At no time are funds transferred to families. All grants awarded are paid directly to the vendor and/or service provider. When filling out the grant application, you must be **VERY specific** on the items needed, where to buy them, and the estimated cost for each item. If money is requested for medically related bills, the billing information and amount is required.

Q: We have so many medical bills, we're having trouble paying the rent/electric/water/telephone bills. Can the Foundation help pay these types of bills?

The guidelines of this grant do not allow payment for anything other than bills or materials that are directly related to your child with autism.

Q: I'm not sure if this request falls within the grant guidelines. Should I still send in an application?

Yes. If your request is for something other than NECESSITIES for your child with autism, it does not fall within the grant guidelines. Those questionable necessities will be determined by the Foundation board members and must be supported by a recommendation letter.

Q: I have health insurance. Can I still apply for assistance?

Yes.



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Please fill out this application in its entirety and print clearly. Illegible applications will not be considered.

Privacy Statement:

The information included in this application will remain private and confidential and is used for Foundation use only.

Child with Autism (If requesting aid for more than one child with autism, please fill out a separate application):

Name: _____ Age: _____

Date of Birth: _____ Social Security #: _____

Mother/Legal Guardian: Check here if you want return mail sent to this address

Name: _____ Relation to Child: _____

Marital Status: _____ Social Security #: _____

Telephone: _____ Email: _____

Street/City/Zip: _____

Employer: _____ Telephone: _____

Employer Address: _____

Father/Legal Guardian: Check here if you want return mail sent to this address

Name: _____ Relation to Child: _____

Marital Status: _____ Social Security #: _____

Telephone: _____ Email: _____

Street/City/Zip: _____

Employer: _____ Telephone: _____

Employer Address: _____

Shipping Address if different from mailing address:

Street/City/Zip: _____



Dependent Children Information:

- 1. Name: _____ Age: _____ Autistic: Yes _____ No _____
- 2. Name: _____ Age: _____ Autistic: Yes _____ No _____
- 3. Name: _____ Age: _____ Autistic: Yes _____ No _____
- 4. Name: _____ Age: _____ Autistic: Yes _____ No _____
- 5. Name: _____ Age: _____ Autistic: Yes _____ No _____

Doctor(s) involved in child’s diagnosis and/or treatment of autism:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Requested Items to be purchased by Foundation if grant is awarded:

Note: Please be **very** specific with your description of monetary help or items needed for your child. At no time will money be awarded directly to families. All grant offerings are paid directly to the vendor and/or service provider. This may include tuition for specific classes, supplements/medication, medical evaluations, learning materials, testing, therapies, etc.

Item #1: _____ COST: \$ _____

Service provider, vendor or place to buy items: _____

Item #2: _____ COST: \$ _____

Service provider, vendor or place to buy items: _____

Item #3: _____ COST: \$ _____

Service provider, vendor or place to buy items: _____

Previous Grants:

Have you previously received funding from Carlos Vieira Foundation? Yes _____ No _____ Year _____

Future Correspondence:

How would you prefer to receive any future correspondence? Via postal mail _____ Via email _____

What language would you prefer for any future correspondence? English _____ Spanish _____

Would you like to be added to our quarterly newsletter mailing list to receive important foundation announcements and updates on future events? Yes, via postal mail _____ Yes, via email _____ No _____



Liability Disclaimer: I hereby release, indemnify and hold harmless The Carlos Vieira Foundation for any injury or accident that may occur, and I will assume all liability in connection with an injury (including any injury caused by negligence) that may occur with any of the awarded items associated with this Direct Grant program. By signing below, I understand and agree to these conditions.

Parents/Guardians: (All legal parents or guardians must sign below)

Print Name: _____

Signature: _____

Date: _____

Print Name: _____

Signature: _____

Date: _____

Please Note:

1. We cannot accept phone calls asking if applications have been received. As soon as the process is complete we will contact you by mail whether you have been approved or not.
2. This application will not be considered until this form is completed legibly, signed, and all supporting documents are received.

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DIRECT HELP PROGRAM
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Livingston, CA 95334



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2018 Carlos Vieira Foundation Direct Help Program
TO HELP FAMILIES LIVING WITH AUTISM

ELECTRONIC DEVICE FORM

(Include this attachment the Direct Help Application)

This _____ is being requested for _____:
(Name of Electronic Device) (Name of Child with Autism)

Information for this form can be gathered from the child’s parents, teacher, AT specialist, physician, or any other professional that can explain how this electronic device will directly help with the child’s autism.

Please fill out this application in its entirety and remember to print clearly as illegible applications cannot be considered.

1. History- what is this individual’s history with use of this electronic device? (i.e. at school, with family, with friends, give examples of success with communication/academic progress, etc.)

2. If used before, what apps or programs were used consistently or tried with this individual?

3. Future primary purpose of the electronic device (reward, academic, communication, behavior, organization)? Please explain:

4. When and where will this electronic device be used?



5. What types of apps or programs will be used most and why?

6. How do you think this device will most help this individual?

7. Who is the person or people who will monitor use of this device?

8. Will the device go to school daily? Is the school currently using this device in the classroom? Please include name and phone number of the individual's teacher.

Note:

This device is to be used solely to help the individual with autism named on the application and not for family members to use for personal reasons.

Name of People who helped to complete these questions:

Name: _____ Relation to Child: _____

Name: _____ Relation to Child: _____

Name: _____ Relation to Child: _____

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