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## Family Scholarship Program Application – DAN (Defeat Autism Now) Doctor

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

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Applicant Name (Last, First)

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Home Address (Street, City, State, Zip)

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Home Telephone

Business/Other Telephone

E-mail Address

CHILD INFORMATION: Do you have a child with autism spectrum disorder living with you?  Yes - Age \_\_\_\_\_  No

Do you have MORE THAN ONE child with autism spectrum disorder living with you?  Yes  No (If yes, how many? Please also provide their ages and diagnosis.)

MARITAL STATUS: Are you married?  Yes  No

Are you a single parent?  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 household income? \_\_\_\_\_

Do you receive state or federal assistance?  Yes  No

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

INSURANCE:

Do you have health insurance for your family  Yes Type: \_\_\_\_\_  No

SERVICES:

What is the name of your School District : \_\_\_\_\_

Do you receive services from your school district?  Yes  No

From your Regional Center or Early Start Program?  Yes  No

Have you filed for hearing against your school district for service issues:  Yes  No

Early Start Program or Regional Center Services?  Yes  No

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: \_\_\_\_\_

TACA ASSSITANCE:

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

Type of services requested: \_\_\_\_\_

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**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 DAN doctor and cost for labs. TACA has provided a sample for your review. It can be found at the link: [http://www.talkaboutcuringautism.org/enewsletters\\_archive/2008/enews-05-08-1.php#anchor9](http://www.talkaboutcuringautism.org/enewsletters_archive/2008/enews-05-08-1.php#anchor9)

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

Please include a breakdown of the costs – DAN doctor visit, lab costs, travel, meals.

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

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_

Fax \_\_\_\_\_

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

Have you attended any of the following: DAN, USAAA or Autism One conferences or a TACA New Parent Seminar? 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.

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Applicant Signature

Date

**Please include the following with this application and mail to  
TACA Family Scholarship Program, 3070 Bristol, Suite 340 Costa Mesa, CA 92626**

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Family Scholarship Program Application

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## **CHECKLIST**

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

- Proof of diagnosis.
  
- Copy of current year to date pay stub for all household wage earners or most recent Tax Return.
  
- Date you became a TACA Member.
  
- Completed summary of previous treatments and explanation of why you chose the DAN doctor you are requesting funding for.
  
- Contact information for DAN doctor.
  
- Cost breakdown – can include estimates from DAN doctor for Lab work and supplements (the DAN doctor’s office should be able to help you with this.)
  
- Explanation of Goals for your child’s visit to a DAN Doctor.