



# Carlos Vieira Foundation Direct Help Application

HELPING FAMILIES LIVING WITH AUTISM

Thank you for participating in our Direct Help Program. Our mission is to provide services, medical necessities, and educational tools to families who live in Central California that are affected by Autism. Please fill out this application in its entirety printing 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.

**Autistic Child** (If requesting aid for more than one autistic child, please fill out a separate application):

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Marital Status: \_\_\_\_\_ 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: \_\_\_\_\_ 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 \_\_\_\_\_

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: \_\_\_\_\_

**Check off List:**

- You must mail in completed application
- You must send in one of the following in order for your application to be approved (school IEP's will not be accepted as diagnosis of Autism):
  1. Proof of Diagnosis of Autism from a School Psychologist
  2. Proof of Diagnosis of Autism from a Regional Center Psychologist/Physician
  3. Proof of Diagnosis of Autism from a Private Psychologist/Physician
- Required: Attach the most recent IRS return/s for both parents or guardians or applications cannot be considered. If you do not file taxes due to Social Security you must provide you award letter.
- If you are requesting an electronic device (i.e. computer, I-Pad, etc.) you will need to attach a recommendation letter from an ATP/RESNA, Assistive Technology Practitioner, Speech/Language Specialist or Occupational Therapist that states how this device will help your child specifically with his/her autism.
- If you are requesting an electronic device (i.e. computer, iPad, etc.) you will need to complete the *Electronic Device Form* and include it with this application.
- Please keep a copy for your records

**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.

*Mail completed application to:*  
CARLOS VIEIRA FOUNDATION  
DIRECT HELP PROGRAM  
6079 Washington Blvd.  
Livingston, CA 95334



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