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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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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