



Carlos Vieira Foundation Direct Help Application

HELPING FAMILIES LIVING WITH AUTISM

The Direct Help Grant Program is offered through the Carlos Vieira 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: Butte, Colusa, El Dorado, Fresno, Glenn, Kern, Kings, Madera, Mariposa, Merced, Placer, Sacramento, San Joaquin, Shasta, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, Yolo, or Yuba.
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 mailing 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/ IPPs will not be accepted as a diagnosis of autism)
- The **1040 form from your most recent tax return** 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 with your child listed as a dependent.
- A recommendation letter** from a 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 Note: iPads and computers cannot be granted two years in a row.
- 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 1040 form from your 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: Is the grant awarded based on annual income?

All families with a child diagnosed with autism are welcome to apply. Annual income is not a deciding factor in the approval process.

Q: What if I am unable to upload a document while completing the application on your website?

If you are unable to upload a document(s), please continue to submit application online and email document(s) to info@carlosvieirafoundation.org.

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

Once an application and all required documentation is received, the grant review board will determine whether or not you have been approved or if additional information is needed. A letter will be mailed or emailed to you within 30 days noting the status of your application.

If you are sent a letter to submit additional information, you will have a period of 5 weeks to submit missing documentation. If you do not submit, a second and final letter will be sent requesting the information. If you do not submit the documentation requested by the deadline noted on the second request letter your application will automatically be closed.

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.

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 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):

Child's Full Name: _____ Age: _____

Date of Birth: _____ Social Security #: _____

County of residence: _____

Parent/Legal Guardian: Check here if you want this person to be the primary contact

Name: _____ Relation to Child: _____

Marital Status: _____ Social Security #: _____

Telephone: _____ *Email: _____

Mailing Address (City, State, Zip): _____

Employer: _____ Telephone: _____

Employer Address: _____

Parent/Legal Guardian: Check here if you want this person to be the primary contact

Name: _____ Relation to Child: _____

Marital Status: _____ Social Security #: _____

Telephone: _____ *Email: _____

Mailing Address (City, State, 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 (make, model, color, etc.). 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. *If you are interested in additional items to total the allowed grant amount of \$500, please email additional items, cost, service provider, vendor, or website/ link to buy items to info@carlosvieirafoundation.org.

Item #1: _____ COST: \$ _____

Service provider, vendor or website/link to buy items:

Item #2: _____ COST: \$ _____

Service provider, vendor or website/link to buy items:

Item #3: _____ COST: \$ _____

Service provider, vendor or website/link to buy items:

Previous Grants:

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

Future Correspondence: Email is the preferred quickest option when processing grants.

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



What language would you prefer for any future correspondence?

English _____ Español _____

By applying for our grant program, you agree to be added to our email list to receive news about CVF programs and events. You can unsubscribe at any time.

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 your preferred method of future correspondence 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



Or complete application online at:
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TO HELP FAMILIES LIVING WITH AUTISM

ELECTRONIC DEVICE FORM

(Only fill this out if you are requesting an electronic device)

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

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

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