PROJECT iAM®
iLaugh iCry iLove iPlay iAm®

Project iAm's goal is to introduce and help facilitate early and on-going treatment by providing the necessary resources including funding, guidance, referrals and follow up to individuals and their families in our local community with Autism Spectrum Disorders. Project iAm is proud to offer a scholarship program for assessments and treatments that may not otherwise be covered privately or by other third-party funding sources such as school districts, county programs, insurance, and/or other scholarship making entities.

Applicants who meet the following scholarship program criteria and complete the Scholarship Application completely, will be considered for Project iAm scholarships. Since in most cases, the applicant's parent or guardian will be completing the application, it is understood that the applicant living with ASD will be the individual receiving the benefits of the scholarship.

Scholarship Making Philosophy
Project iAm scholarships are designed to provide financial support to individuals and families affected by Autism Spectrum Disorders. Scholarship payments will be made directly to pre-approved treatment providers, assessors or materials vendors for the applicant's needs.

Amount Requested
Scholarships will be allocated based on annual fund-raising activities. The Scholarship Committee will determine the number and amounts of each scholarship on a case by case basis. Requests for endowments or multi-year scholarships will not be accepted and scholarship recipients must re-apply each term. Because we are 100% volunteer based, preferential treatment will always be given to those that volunteer for Project iAM.

Applicants must demonstrate financial need by providing the following:
- **Proof of Household income for two years**
- **Number of Dependents**
- **Number of Dependents with Autism Spectrum Disorders**
- **Information about access to third-party funding sources**
- **Previous attempts at securing financing through Providers**

The Following must be sent to Project iAm in order to be eligible for scholarships:
- **Completed, signed and dated scholarship Application by deadline**
- **Verification of Diagnosis from an M.D. Or D.O.**
- **Assessment from Provider of Treatment Assessment**
- **Documentation from Provider of Treatment of Applicant's Enrollment**
- **Assessment of Costs from Provider for Applicant's therapy**
- **500 Word Description of your child's story**
- **Copy of Previous two Years' Tax Returns**

The committee will review scholarship Applications and make decisions on who should receive scholarships .Incomplete scholarships will not be considered.

Applications must be mailed to:

3851 River Road
Toledo, OH 43614

Applicant receiving a scholarship agrees to repay the scholarship if any services paid for with the scholarship are reimbursed by another funding source, such as, a school district or insurance company.

Today's Date: _____

How did you hear about Project iAm Scholarships? (please list name if referred by a person)
_____

Have you previously applied for an iAm grant? No Yes, Date _____ Outcome_____

General Information

Applicant's Name (Child effected by Autism Spectrum):	Applicant's Date of Birth:
Applicant's Current Age:	Applicant's Gender:
Street Address:	
City, State, Zip Code:	
1) Guardian #1 Name:	Relationship:
Home Telephone Number:	Cell Number:
Work Telephone Number:	Email Address:
2) Guardian #2 Name:	Relationship:
Home Telephone Number:	Cell Number:
Work Telephone Number:	Email Address:

Dependant/Sibling Information

Name:	Age:	Relation to Applicant:	Autism Spectrum Disorder Diagnosis (Yes or No)

History

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the iAm Scholarship review process. I give Project iAm permission to verify treatment information by contacting the treatment vendors directly. This authorization shall be valid for one year unless otherwise stated.
I understand that I may revoke this authorization in writing at any time.

_____ _____

Signature Date

Current Diagnosis:	Date of Diagnosis:
Diagnosed by: (Name of Physician)	
Name of Institution where Diagnosed:	Telephone Number:
Street Address:	City/State/Zip:

Treatment

List all previous treatment's obtained (i.e. Spech Thearapy, Occupational Therapy, ABA Therapy, Biomedical Testing, Etc.)

Scholarship Request (Treatment, Assessments/Testing, or Materials)

Check all that apply, complete requested information and include copies of supportive documentation, such as, letters of support from service providers, service/intervention descriptions, treatment cost sheets, provider brochures, receipts etc.

Financial Request #1

Type of Request: (Treatment, Assessments/Testing, or Materials)	
Provider Name:	Phone Number:
Provider Address:	Provider City/State/Zip
Describe details: (Include who will provide treatment, assesments/testing, or materials)	
Total Cost out of Pocket Cost to Parent: $	Total Cost Requested from Project iAm: $

Financial Request #2

Type of Request: (Treatment, Assessments/Testing, or Materials)	
Provider Name:	Phone Number:
Provider Address:	Provider City/State/Zip
Describe details: (Include who will provide treatment, assesments/testing, or materials)	
Total Cost out of Pocket Cost to Parent: $	Total Cost Requested from Project iAm: $

Other Funding Sources

Have you ever applied for funding through the treatment Provider for which you are applying?

No

Have you applied for Private/Health Insurance Funding for treatment request?

No

Have you applied for your School District for treatment funding?

No

Have you applied you applied for any other scholarships or grants for your request?

No

If your answer is no to all of the above questions please explain why you have not applied for any of these available resources (you may use a separate sheet of paper if you need more space):

If you have applied please explain the outcome of your application (you may use a separate sheet of paper if you need more space):

Guardian #1 Monthly Gross Income: $	Source of Guardian #1 Income:
Guardian #2 Monthly Gross Income: $	Source of Guardian #2 Income:

Please tell us your child's story in your own words (you may use a separate sheet of paper if you need more space):

Letters of Recommendation (optional)
Please attach no more than two letters of recommendation from service providers, case workers or other individuals familiar with your family's situation. Letters of recommendation are optional and should be no more than one page in length.

Have you ever volunteered for a Project iAm event? No

If so, what event? _____

Have you ever attended a Project iAm event? No

If so, what event? _____

FINAL CHECK LIST:

Qualified Medical Diagnosis Verification No

Provider Treatment Verification No

Provider Support Documents to Verify Costs No

Provider Assessment Verification No

Copy of 2 Previous Year's Tax Return Submitted No

Child's Story in your own Words No

I hereby release **Project iAm** to use my story, photographs, reproductions, video tapes, recordings or endorsements of /by me and/or my child for publicity, fundraising or any other purpose.

Name of Parent: _____

Description of Use: _____

I hereby grant Project iAm the following rights:

1. To use my / my child's first name (you may ask that names are withheld - see below), photograph, picture, portrait, likeness, and voice in connection with its educational materials or publicity or for any other legitimate reason
2. To use, reproduce, publish, exhibit, distribute, and transmit my/ my child's image individually or in conjunction with other images or printed matter in the production of brochures, motion pictures, television tape, sound recordings, still photography, website, social media, CD-ROM, and other media
3. To record, reproduce, and amplify my image and all sound effects produced
4. To use my story and our daily adventures with Autism.

I hereby release and discharge Project iAm from any and all claims, actions and demands arising out of or in connection with the use of said image, including, without limitation, any and all claims for invasion of privacy and libel. I hereby waive the right to inspect or approve my/ my child's image or any finished materials that incorporate my image. I understand and agree that I will receive no compensation, now or in the future, in connection with the use of my/ my child's image.

I represent that I have read the preceding and completely understand the contents.

Authorizer's Name:_____

Child's Name:_____

Signature of Parent or Guardian: _____

Relationship to Client: _____Date:_____

Street Address:_____ City: _____ State: _____ Zip: _____