iLaugh. iCry. iLove. iPlay. iAm. iLaugh. iCry. iLove. iPlay. iAm. iLaugh. iCry. iLove. iPlay. 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 and by the deadline date, 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 Board of Directors will determine the number and amounts of each scholarship at the beginning of each term. Requests for endowments or multi-year scholarships will not be accepted and scholarship recipients must re-apply each term. Once an applicant receives a scholarship, there will be a three year waiting period before reapplying.

- 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 Board Members will review scholarship Applications and make decisions on who should receive scholarships. Please note, there are no set application deadlines; they are posted on our website as scholarships become available. Scholarship Applications must be post marked no later than the deadline date specified. Incomplete scholarships will not be considered. No Faxed or Emailed scholarship Applications will be accepted
scholarship Applications must be mailed to :

Project iAm
ATTN: Scholarship Committee
3818 Frampton Dr.
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.

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Scholarship Application

Please type or print clearly in the form below.

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: ❑ FEMALE ❑ MALE
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
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO
Name:	Age:	Relation to Applicant:	❑ YES ❑ NO
Name:	Age:	Relation to Applicant:	❑ YES ❑ 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 Code:

Treatment

Type of Treatment	**Treatment History** (please check one)	**Frequency** (example: 2hrs per week)	**Provider of Services**	Previously applied for funding?
Speech Therapy	❑ Current ❑ Past ❑ Not applicable			
Occupational Therapy	❑ Current ❑ Past ❑ Not applicable			
Physical Therapy	❑ Current ❑ Past ❑ Not applicable			
Applied Behavior Analysis	❑ Current ❑ Past ❑ Not applicable			
Special Diets	❑ Current ❑ Past ❑ Not applicable			
Biomedical Testing	❑ Current ❑ Past ❑ Not applicable			
Biomedical Intervention	❑ Current ❑ Past ❑ Not applicable			
Social Skills Groups	❑ Current ❑ Past ❑ Not applicable			
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable			
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable			
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable			
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable			
Other: (please explain)	❑ Current ❑ Past ❑ Not applicable			

Scholarship Request

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.

❑ Direct Treatment

Total Cost of Treatment: $	Scholarship Requested for Treatment: $	Supportive Documentation Attached: ❑ Yes ❑ No (If "No" application will not be considered)

Scholarship Request is for the following Service/Intervention(s):

Provider Name:	Provider Contact Telephone Number:

Street Address:

City:	State:	Zip Code:

Describe details: (Include who will provide treatment, frequency and duration of treatment, etc.)

❑ Assessments or Testing

Total Cost of Assessment/testing: $	Scholarship Requested for Assessment/Test(s): $	Supportive Documentation Attached: ❑ Yes ❑ No (If "No" application will not be considered)

Scholarship Request is for the following Service/Intervention(s):

Provider Name:	Provider Contact Telephone Number:

Street Address:

City:	State:	Zip Code:

Describe details: (Include who will provide testing at what frequency and purpose)

❑ Materials

Total Cost of Assessment(s): $	Scholarship Requested for Assessment(s): $

Scholarship Request is for the following Service/Intervention(s):

Provider Name:	Provider Contact Telephone Number:

Street Address:

City:	State:	Zip Code:

Describe details: (Include reason materials required)

Financial Information

Guardian #1 Monthly Gross Income:	$ Please attach copy of previous 2 years Tax Return
Guardian #2 Monthly Gross Income:	$ Please attach copy of previous 2 years Tax Return
Other Sources of Income: Source:	
Monthly Gross Amount:	$
Source:	
Monthly Gross Amount:	$

Funding Sources (including other grants or scholarship awards)

Check all funding sources that apply and complete the requested information.

❑ Private/Health Insurance

Insurance Company:	Contact Person:	Telephone Number:
Treatments Covered:		

❑ Regional Center

Regional Center:	Contact Person:	Telephone Number:
Services Provided:		

❑ School District

School District:	Contact Person:	Telephone Number:
Services Provided:		

❑ County

County:	Contact Person:	Telephone Number:
Services Provided:		

❑ Other

Describe:	Contact Person:	Telephone Number:
Services Provided:		

❑ Other

Describe:	Contact Person:	Telephone Number:
Services Provided:		

Description of Family Situation

On a separate sheet of paper, please tell us your child's story in 500 words or less

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

Please explain in the space below why or why not and the outcome:

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? YES or NO

If so, what event?_____

Have you ever attended a Project iAm event? YES or NO

If so, what event?_____

FOR OFFICE USE ONLY

Application Received by Scholarship Deadline	❑ YES	❑ NO
Qualified Medical Diagnosis Verification	❑ YES	❑ NO
Provider Treatment Verification	❑ YES	❑ NO
Provider Support Documents to Verify Costs	❑ YES	❑ NO
Provider Assessment Verification	❑ YES	❑ NO
Copy of 2 Previous Year's Tax Return Submitted	❑ YES	❑ NO
500 Word Description of Situation Submitted	❑ YES	❑ NO

Board Review

❑ Approved ❑ Declined - Reason: _____

Amount Approved: $	Date Applicant Notified:	Board Approval Signature:	Date:

Comments/Notes:

RELEASE AND AUTHORIZATION FOR USE OF IMAGE

I hereby release Project iAm to use 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, CD-ROM, and other media
3. To record, reproduce, and amplify my image and all sound effects produced

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: _____

Authorized Use of Name (please circle one): Yes No