

Walk for Autism Charleston Application

Deadline for submitting this application: **April 30th**

Application Date: _____

Please mail your completed application packet to:

Walk for Autism-Charleston
P.O. Box 62097
North Charleston, SC 29419

PART I:

Child's Name: _____

Child's Date of Birth: _____ (child is no longer eligible after their 22nd birthday)

Date of Diagnosis of PDD/ASD: _____

**** Documentation of Diagnosis from MD must be attached. **** Form located on our website

Home address: _____

City _____ State: _____ Zip Code: _____

Telephone Number: _____ Alternate Phone number: _____

Email Address: _____

PART II: WFA scholarships are for families who do not have access to funding via their insurance or PDD waiver. Please provide us with your current eligibility.

Do you have medical insurance? _____ no _____ yes

If yes, does your policy cover ABA or RDI services? _____ No _____ yes

Name of Insurance carrier: _____

Secondary Insurance carrier: _____

Do you have the PDD Waiver? _____ No _____ yes (expiration of eligibility: _____)

Are you on the PDD waiver waiting list: _____ no _____ yes

Contact Information: Info@WalkforAutismCharleston.org
Rose O'Neal, Controller, and rrzoneal@hotmail.com

PART II- CURRENT PROGRAM NEEDS

I understand that my child may be eligible to receive a scholarship from the Walk for Autism for the purpose of conducting an in-home program for (Applied Behavioral Analysis) or RDI (Relationship Development Intervention) based on completion of this application before the application deadline and for completing the necessary documentation requested.

***A. Option I. Applied Behavioral Analysis (ABA)**

1. Do you currently have an existing ABA program? If yes, please briefly describe your program. If not, what program do you plan on implementing? Please read carefully the reimbursement procedures on **Form A**. Submit form A with your application.

OR

***B. Option II. Relationship Development Intervention (RDI)**

1. Do you currently have an existing RDI program? If yes, please briefly describe your program. If not, what program do you plan on implementing? Please read carefully the reimbursement procedures on **Form B**. Submit form B with your application.

***C. Option III. Alternative Therapies**

- Applicants that may qualify for our full scholarships will be permitted to use 20% of the awarded amount on Alternative Therapies. **Monies cannot be used to pay for insurance co-pays.**
- Alternative Therapies may include though are not limited to horseback riding, music therapy, vision therapy, therapeutic listening etc.
- Please read carefully the reimbursement procedures on **Form C**. Submit form C with your application.

PART III

TERMS AND CONDITIONS

- **I understand that my child is eligible to receive funding only for the purpose of conducting an in-home ABA or RDI program. Approximately 20% of your application can be used toward other alternative therapies that are not covered by insurance or the PDD Waiver.**
- **I understand all applicants must be under the age of 22 to qualify.**
- **I understand that the Walk for Autism Scholarship Fund has been established primarily for the purpose of the intervention and treatment of autism.**
- **I understand as the parent that the provider of services is not a family member, living in or out of the home, or a close family friend who otherwise regularly spends time in the home in regards to reimbursement.**
- **I understand that all monies will be dispersed equally amongst all qualified recipients within 60 days of the walk event and in accordance with the federal tax laws governing 501 (c) (3) agencies.**
- **I understand that Walk for Autism provides scholarships for a period of one year.**
- **I understand that any unused portions of my scholarship, as specified by this application, will return to Walk for Autism.**
- **I understand that if at any time I discontinue my ABA or RDI program, I am required to notify Walk for Autism in writing and my scholarship will return to the organization.**
- **I understand that I am responsible for verification and documentation of costs incurred in conducting my in-home ABA or RDI program and that I am required to submit forms specified by this application in a timely manner and in due process.**
- **I understand that I am responsible for filing 1099 forms as stated by the IRS for therapists and consultants who work specifically as independent contractors.**
- **I understand that any and all information pertaining to my application and scholarship is confidential. And does not affect scholarship allocation. Information is gathered in the event of an IRS audit.**
-

Our mission is simple: raise funds here, support families here, and make a difference here.

✿ To help us keep that promise, scholarship applicants and recipients must remain in South Carolina to be eligible for funding. If you move outside our service area, you will no longer be eligible to apply for or receive any remaining scholarship funds.

- **I have read the preceding information. I understand and agree to the terms and conditions stated above.**

o **Signature of parent or legal guardian**

Date
