C.A.D.E.

Children with Autism Deserve Education

CHILDREN WITH AUTISM DESERVE EDUCATION
501©3 non-profit organization in MN

CADE Medical & Therapy Grant Application

Children with Autism Deserve Educations' (CADE for this document) goal is to introduce and help facilitate early biomedical treatment and therapy support by providing resources to individuals with Autism Spectrum Disorders. CADE is proud to offer a grant program for 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 grant making entities.

The biomedical grant and therapy grants are available to families on the basis of board approval.

These grants are for CADE approved physicians & CADE approved therapy programs. The program you are hoping to impact with this grant must be listed in your personal essay.

Applicants who meet the following grant program criteria will be considered for a *CADE* grant. Since, in most cases, the applicant's parent or guardian will be completing the application, it is understood that the applicant will be the individual receiving the benefits of the grant.

CADE Medical & Therapy Grant

Medical grants are designed to provide support to individuals affected by Autism Spectrum Disorders. Each grant recipient will receive 2-doctor visits with a specially trained physician who treats autism; $250 worth of supplements will be given to the child based on doctor recommendation.

Therapy grants are designed to provide support to individuals affected by Autism Spectrum Disorders. Each grant recipient will receive $3000 as a portion to help cover pre-existing condition waits, copays & fees for therapy. These dollars will be paid directly to a service provider.

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Grant Guidelines

Applicants must:

- Provide proof of household Income
- # of dependants
- # of dependents with Autism Spectrum Disorder
- Information about what current funding the grantee is receiving (i.e. medical & therapeutic)

The following must be mailed to C.A.D.E. in order to be considered for a grant:

- Completed, signed and dated Grant Application
- Verification of Diagnosis – Evaluation report or prescription from diagnosing physician
- No more than 500 Word description of current family situation (descriptions exceeding this amount will not be considered) as a personal essay
- Copy of previous years' tax return (no bank statements or check stubs will be accepted)

CADE grant awards are based on economic need as defined by a percentage beneath the median income of Minnesota.

- Grant applications must be mailed to the address below.
- Faxed or emailed grant applications will not be accepted
- Grant applications must be mailed to:

CADE Attn: CADE Board of Directors
6533 Flying Cloud Drive, Suite 1200
Eden Prairie, MN 55344

Incomplete grant applications will not be considered.

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CADE Medical & Therapy Grant Application

Today's Date: _____

General Information		
Applicant's Name (Child affected by Autism):		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: (required) You will be notified through this email.	
2) Guardian #2 Name:		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address: (required)	Child's Weight:

Dependant/Sibling Information			Disorder/Diagnosis
Name:	Age:	Relation to Applicant:	! YES ! NO Diagnosis:
Name:	Age:	Relation to Applicant:	! YES ! NO Diagnosis:
Name:	Age:	Relation to Applicant:	! YES ! NO Diagnosis:

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History

- **Consent:** This form authorizes the use and/or release of the protected health information as noted below for purposes of the CADE grant review process. I give Children with Autism Deserve Education 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:
Current Age:		Age at Diagnosis:	
Name of Institution where Diagnosed:			Telephone Number:
Street Address:	City:	State:	Zip Code:

Treatments

Type of Treatment	Treatment History (please check one)	Frequency	Provider of Services
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		
Supplements	! Current ! Past ! Not applicable		
Supplements	! Current ! Past		

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Prescription Drugs

! Current ! Past
! Not applicable

Prescription Drugs

	! Current ! Past ! Not applicable		

Financial Information

Guardian #1 Yearly Gross Income:	**$** *Please attach a copy of previous year's Tax Return**
Guardian #2 Yearly Gross Income:	**$** *Please attach a copy of previous year's Tax Return**
Other Sources of Income: (Regional Center, IHSS, SSI)	**$**
Total Yearly Gross & Other Income: *(no other income source will be accepted)	**$**

Funding Sources: (including other grants or scholarships 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:		

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!County		
County:	Contact Person:	Telephone Number:
Services Provided:		
!Other		

Describe:	Contact Person:	Telephone Number:

Services Provided:

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Please read each of the following statements carefully and initial if true.

____ 1. I understand that my child is required to follow the **GF/CF diet** or **SCD** diet for the 90-day grant period if the medical grant is awarded and the diet is recommended.

____ 2. I understand that an approved Doctor will be assigned to my child and that I have no choice in this matter and cannot change the assigned doctor. This doctor will be a specially trained for autism.

____ 3. I understand that a medical provider may consist of Medical Doctors, Chiropractors, Nutritionists, Nurse Practitioners, and other health professionals.

____ 4. I understand that I am responsible for scheduling my child's doctor appointments with the assigned doctor.

____ 5. I understand that if I miss my child's scheduled doctors appointment or cancel without giving 24hr notice, that I am responsible for any fees incurred.

____ 6. I understand that CADE will **not** be paying for any lab testing or blood work.

____ 7. I understand that CADE will **be paying** for $250 worth of prescribed supplements. Unused dollars will be on a credit at the medical professional's office.

____ 8. I understand that a therapy grant will only be given for CADE qualified providers.

____ 9. I understand that the therapy grant will be $3000 paid directly to the providers.

____ 10. I understand that I must specify which provider I am hoping to use & how the money will be spent.

I am applying for a therapy grant _____

I am applying for a medical grant _____

I have read the above statements and fully understand each of them. I understand that by not complying with any of the above statements I forfeit my child's participation in the grant program. I will be held responsible for returning anything sent from C.A.D.E. back to them at my cost.

_____ _____

Signature of parent/guardian Date

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Description of Family Situation Family Essay

On a separate sheet of paper, please describe your current family situation in 500 words or less.

Disclaimer

If you are chosen for the CADE Medical or Therapy grant, you agree to the following:

- Implement ASD diet such as GF/CF or SCD for the medical grant
- Dropping out of the program once selected will make you liable for the following:
  1. All postage costs
  2. The fee(s) of 2(two) Medical visits (estimated at $750.00)
- Document the child's progress through a daily journal and pre and post photographs or a Flip video camera that will be provided if needed.
- All dollars for therapy grants go directly to the provider.

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

Parent/Guardian's Name: _____

Child's Name: _____

Signature of the Parent or Guardian: _____

Relationship to Child: _____

Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorized Use of Name: Yes No

---------- **office use only** ----------

Application Received by Deadline	
Diagnosis Verification	
500 word Family Summary	
Copy of Previous Year's Tax Return Submitted	
Median Income for Zip Code	

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Grant Committee

Approved Denied - Reason:
