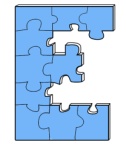
** MMA’S EMMBASSADORS**

Empowering Families Affected by Autism

# Grant Request FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s Date: 4/10/2018 | | | | | | | | | | | | EERN (to be completed by EE): | | | | | | | | | | | | | | | | | | | | |
| Grant Recipient INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Grant recipient last name: | | | | | | | | | | | First: | | | | Middle: | | Mr.  Mrs. | Miss  Ms. | | | Marital status: | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  |  | | | Single  Mar  Div  Sep  Wid | | | | | | | | | | | |
| Is this your legal name? | | | | If not, what is your legal name? | | | | | | | | | | | (Former name): | | | | | | | | | | Birth date: | | | Age: | | Sex: | | |
| Yes | | No | |  | | | | | | | | | | |  | | | | | | | | | |  | | |  | | M | F | |
| Street address: | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | Home phone no.: | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | (     ) | | | | | | |
| P.O. box: | | | | | | | City: | | | | | | | | | | | | | State: | | | | | | | ZIP Code: | | | | | |
| Occupation: | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | | | | | | | (     ) | | | | | | |
| Autism Diagnosis information: | | | | | | | | Dr. | | | |  | | | Date of diagnosis | | | | | | | | | | | Can we contact this Doctor?  Yes  No | | | | | | |
| How did you hear about EE? | | | | | | Friend  Webpage  Therapy provider  Other | | | | | | | | | | | | | |  | | | If no, please explain why | | | | | | | | | |
| Other family members with Autism: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Family INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for recipient: | | | | | | | | Birth date: | | | | | | | Address (if different): | | | | | | | | | | | Home phone no.: | | | | | | |
|  | | | | | | | |  | | | | | | |  | | | | | | | | | | | (     ) | | | | | | |
| Relationship of potential grant recipient? | | | | | | | | Parent | | | | | | Grandparent | Legal Guardian  Other, please explain | | | | | | | | | | | | | | | | | |
| Occupation: | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | Employer phone no.: | | | | | | |
|  | | |  | | | | | | | | | | |  | | | | | | | | | | | | (     ) | | | | | | |
| Is the potential grant recipient covered by Medicare? | | | | | | | | | | Yes | | | | No |  | | | | | | | | | | | | | | | | | |
| Please indicate primary Grant Request | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Value of Grant Request | | | | | Describe how you would define success or failure of this grant (please include timeline and next actions if failure): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| $ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Therapy provider: | | | | | | | | | | | | | Type of therapy provided: | | | | | | | | | Phone no.: | | | | | | | Policy no.: | | | |
|  | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |  | | | |
| Emma’s Emmbassadors (EE) provides assistance to individuals and families affected by Autism. Requestors must complete this form to be considered for grant assistance. Emma’s Emmbassadors awards grants based upon need and eligibility as determined by the Executive Committee and reserves the sole and exclusive right to make the final determination as to the grant recipients. EE is an IRS 501(c) (3) corporation and does not discriminate on the basis of race, color, religion, age, gender or national origin.  By executing this form, the undersigned authorizes EE and its duly authorized officers and representatives to obtain all medical, psychological or other information which may be required by the Executive Committee in its sole discretion from any health care provider relating to the grant recipient and waives any additional HIPPA requirements. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The above information is true to the best of my knowledge. I authorize Emma’s Emmbassadors to request information from all providers listed above. I understand that Emma’s Emmbassadors is not responsible for any property or bodily harm caused by granted equipment or services. I further understand that by completing this form, the grant is not necessarily awarded and that my family may be contacted for more information. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | |  | | | | | Date | | | | | | | |  |

Emma’s Emmbassadors Inc.

5582 Bostwick Ct., Norcross, GA 30092 EIN 27-1753690