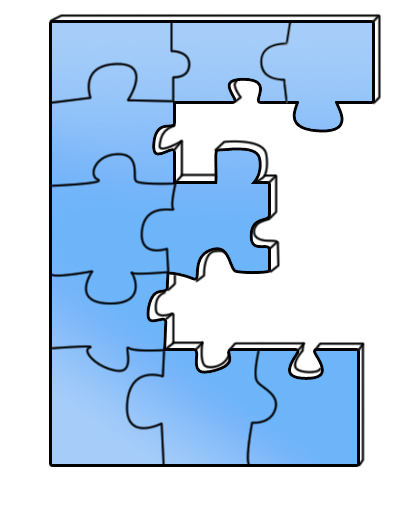
**MMA’S EMMBASSADORS, Inc.**



**Empowering Families Affected by Autism**

Today’s Date:­

How did you hear about the Emma’s Emmbassadors Grant Program? (Please list the name if referred by a person)

Have you previously applied for an Emma’s Emmbassadors Grant? 🞎Yes 🞎No

If yes, what is the approximate date when applied?

What was the outcome?

**GENERAL INFORMATION**

Applicant’s Name (Child affected by Autism Spectrum) Applicant’s Gender 🞎 Male 🞎 Female

Applicant’s Date of Birth Applicant’s Current Age

Street Address City State Zip Code

1) Parent/Guardian #1 Name Relationship

Home Telephone Number Cellular Telephone Number

Work Telephone Number Email Address

2) Parent/Guardian #2 Name Relationship

Home Telephone Number Cellular Telephone Number

Work Telephone Number Email Address

🞎 Check this box if at least one parent or guardian of the applicant serves or has served in the United States Armed Forces. Please indicate date and branch of service:

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**DEPENDANT/SIBLING INFORMATION**

Name Age Relationship to Applicant

Autism Spectrum Disorder Diagnosis 🞎 Yes 🞎 No

Name Age Relationship to Applicant

Autism Spectrum Disorder Diagnosis 🞎 Yes ⬜ No

Name Age Relationship to Applicant

Autism Spectrum Disorder Diagnosis 🞎 Yes ⬜ No

Name Age Relationship to Applicant

Autism Spectrum Disorder Diagnosis 🞎 Yes ⬜ No

Name Age Relationship to Applicant

Autism Spectrum Disorder Diagnosis 🞎 Yes ⬜ No

Name Age Relationship to Applicant

Autism Spectrum Disorder Diagnosis 🞎 Yes ⬜ No

**MEDICAL HISTORY**

**Consent:** This form authorizes the use and/or release of the protected health information as noted below for purposes of the Emma’s Emmbassadors grant review process. I give Emma’s Emmbassadors 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

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**TREATMENT HISTORY**

Type of Treatment Treatment History Frequency Provider of Services

(please check one) (ie: 2 hrs a week)

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**GRANT FUNDS 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.

**Supportive documentation must include cost of treatment/items.**

**Direct Treatment**

Total Cost of Treatment Grant Amount Requested Treatment ⬜ Supportive Documentation Attached

Grant Request is for the above Service/Intervention(s)

Provider Name Provider Contact 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 Grant Amount Requested ⬜ Supportive Documentation Attached

Grant Request is for the above Service/Intervention(s)

Provider Name Provider Contact Number

Street Address City State Zip Code

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

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**Materials**

Total Cost of Materials Grant Amount Requested ⬜ Supportive Documentation Attached

Grant Request is for the above Materials

Provider Name Provider Contact Number

Street Address

City State Zip Code

Describe Details: (Include reason materials required.)

**FINANCIAL INFORMATION**

Guardian #1 Current Gross Monthly Income Gross Annual Income (Attach last year’s tax return)

Guardian #2 Current Gross Monthly Income Gross Annual Income (Attach last year’s tax return)

Other Source of Income Gross Monthly Amount

Other Source of Income Gross Monthly Amount

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**FUNDING SOURCES**

(including other grants or scholarship awards from other entities)

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 Sources of Funding not specified above**

Describe Contact Person Telephone Number

Services Provided

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**DESCRIPTION OF FAMILY SITUATION**

Please describe in 200 words or less your family situation. You may use the space below or attach a separate sheet. ⬜ If you attach a separate sheet please check this box.

**LETTERS OF RECOMMENDATION**

Please attach two letters of recommendation from service providers, case workers, or other individuals familiar with your family’s situation. Letters of recommendation should be no longer than one page in length.

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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.

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.

Signature Date

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**FOR OFFICE USE ONLY**

Application postmarked by deadline ⬜ Yes ⬜ No

Diagnosis Verification ⬜ Yes ⬜ No

Treatment Verification ⬜ Yes ⬜ No

Support Documents to Verify Cost Attached ⬜ Yes ⬜ No

Assessment Verification ⬜ Yes ⬜ No

Copy of Previous Year’s Tax Returns Attached ⬜ Yes ⬜ No

200 Word Description of Family Situation ⬜ Yes ⬜ No

Two Letters of Recommendation ⬜ Yes ⬜ No

Consent to Release Protected Health History signed ⬜ Yes ⬜ No

Consent to Criminal Background Check signed ⬜ Yes ⬜ No

⬜ Approved ⬜ Declined- Reason:

Amount Approved: $

Date Applicant Notified:

Board Approved Signature: Date:

Comments/Notes:

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**RELEASE AND AUTHORIZATION FOR USE OF IMAGE**

I hereby release Emma’s Emmbassadors to use photographs, reproductions, videotapes, 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 Emma’s Emmbassadors 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 purpose;

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 recording, 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 Emma’s Emmbassadors from any and all claims, actions, and demands arising out of or in connection with the use of said images, 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 images 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 images.

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

Authorizer’s Name:

Child’s Name:

Signature of Parent or Guardian: Date:

Relationship to Client:

Street Address:

City: State: Zip Code:

Authorized Use of Name (please check one): ⬜ Yes ⬜ No

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**CONSENT TO CRIMINAL BACKGROUND CHECK**

**Consent:** This form authorizes a board member of Emma’s Emmbassadors to speak with representatives of any law enforcement reporting agency to include without limitation, the N.C.I.C. and G.C.I.C in order to obtain the necessary criminal history, if any. To that end, all representatives of any criminal history reporting agency are hereby authorized to speak with Emma’s Emmbassadors or any attorney from the law firm of Jacobs & King, LLC regarding the aforementioned matters and further to provide them with all records relating to the criminal history.

Signature Date

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**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED**

**HEALTH INFORMATION AND OTHER RECORDS**

By executing this form, the undersigned authorizes Emma’s Emmbassadors 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.

NAME: DOB: SSN:

I HEREBY GRANT PERMISSION TO AND AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL’S RECORDS AS DESCRIBED BELOW TO THSES DESIGNATED ENTITIES:

Emma’s Emmbassadors

5582 Bostwick Court, Norcross, Georgia 30092

and/or:

THE FOLLOWING INDIVIDUAL(S), MEDICAL PROVIDER(S), AND/OR ORGANIZATION(S) ARE AUTORIZED TO MAKE THE DISCLOSURE:

1. 5.

2. 6.

3. 7.

4. 8.

**DATES REQUESTED**: , up to and including, the present date.

1. Complete and Entire Medical File including, but not limited to: Medical Reports, Records/Notes, Itemized Billing, correspondence, photographs, S-Rays/diagnostic studies, diagnostic films, laboratory results, information regarding HIV/AIDS, sexually transmitted diseases or other communicable disease information, references to drug or alcohol use, and mental health treatment, etc.;

2. Personnel, Attendance, Employment, Payroll, Wage Records, School Records and Transcripts, etc.;

3. Insurance Records, including all Claims, Itemized Billing, Correspondence, Payments and all documents within the file, etc.;

4. Traffic Accident Reports, Police Photographs, and Investigation regarding any criminal and/or civil litigation matter, etc.

**PURPOSE**: The above information is being obtained to assist said authorized entities in evaluation of my claim for benefits or damages. A copy of facsimile of this document shall be considered as effective and valid as the original.

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I understand I have the right to revoke this Authorization at any time. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this Health Information is voluntary and that I am entitled to a copy of this Authorization and acknowledge receipt of a copy thereof. I can refuse to sign this Authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

Date:

Patient/Natural Parent/Guardian/Legal Representative

SUBSCRIBED and SWORN TO before me on

this day of , 2011.

STATE:

COUNTY:

NOTARY PUBLIC of Said State and County (SEAL)

My Commission Expires:

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