

## Family Scholarship Program Application – DAN (Defeat Autism Now) Doctor

Summary: This application is for families who meet the eligibility criteria and want to pursue Biomedical Treatment. Please present a complete proposal requesting funding, including cost breakdown.

Applicant Name (Last, First) \_\_\_\_\_ Parent or primary caregiver

Home Address (Street, City, State, Zip) \_\_\_\_\_

Home Telephone \_\_\_\_\_

Business/Other Telephone \_\_\_\_\_

E-mail Address \_\_\_\_\_

COMPLETE THE FOLLOWING INFORMATION FOR CHILDREN LIVING WITH YOU:

Please list child's first name \_\_\_\_\_

Birth date \_\_\_\_\_ diagnosis if any \_\_\_\_\_

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Birth date \_\_\_\_\_ diagnosis if any \_\_\_\_\_

(write on back if more than 3 children)

MARITAL STATUS: Are you married?  Yes  No

If you are a single parent, do you receive monthly child support?  Yes  No If yes, how much \$ \_\_\_\_\_

INCOME:

What is your combined monthly household employment income? \_\_\_\_\_

Do you receive state or federal assistance (SSI/SDI)?  Yes  No If yes, how much per month \$ \_\_\_\_\_

INSURANCE:

Do you have private health insurance for your child  Yes Type: \_\_\_\_\_  No

Do you have state paid insurance (i.e. Healthy Kids or Medicaid/MediCal)?  Yes Type: \_\_\_\_\_  No

SERVICES:

If your child is 0-3 is your child in Early Start/Early Intervention?  Yes  No

If your child is over age 3 what is their current school placement? Public/Private/In-Home Program \_\_\_\_\_

CURRENT FAMILY DEBT:

HOUSING:  Own Home  Rent  Temporary Housing Monthly housing commitment \$ \_\_\_\_\_

Do you have a 2<sup>nd</sup> mortgage on your home:  Yes  No Monthly housing commitment 2<sup>nd</sup> Mortgage \$ \_\_\_\_\_

Credit card debt:

Number of credit cards your family has: \_\_\_\_\_ Current Balance \$ \_\_\_\_\_ Monthly Minimum Payments \_\_\_\_\_

TACA MEMBERSHIP: Date of first TACA meeting Attended: \_\_\_\_\_ or Date you joined TACA on the web: \_\_\_\_\_  
(Required: Must be a TACA member for a minimum of 6 months prior to applying for a DAN Doctor Scholarship)

NAME OF PARENT MENTOR: \_\_\_\_\_  
(Required: Must have a Parent Mentor for at least 2 months prior to applying for a DAN Doctor Scholarship)

Date you Joined TACA-USA Yahoo Group: \_\_\_\_\_ (Required)

TACA ASSITANCE:

Have you ever received assistance from TACA before? If so, please note the amount, for what and when.  Yes  No

Type of services awarded previously: \_\_\_\_\_

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**Proposal SUMMARY:**

**ON SEPARATE SHEETS OF PAPER PLEASE PROVIDE THE FOLLOWING:**

Please describe what is being requested and why. Be specific. For example: First visit to a DAN doctor and cost for labs. TACA has provided a sample for your review. It can be found at the link:  
[http://www.talkaboutcuringautism.org/enewsletters\\_archive/2008/enews-05-08-1.php#anchor9](http://www.talkaboutcuringautism.org/enewsletters_archive/2008/enews-05-08-1.php#anchor9)

Please outline all of the current therapies and treatments your child is receiving. Are you currently implementing a special diet? If not, would you be willing to do so as a requirement of seeing a DAN Doctor. Are you implementing biomedical intervention? If so, what have you tried so far? Are you working with a DAN Doctor? If so, who?

Please include a breakdown of the costs – i.e. DAN doctor visit, lab costs, etc.

Please make sure you have read (TOP TEN Links) document that discusses what items will likely NOT be funded by a TACA Family Scholarship.

Please include contact information for the practitioner you have chosen to use should the scholarship be funded.

Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Please make it clear to the committee where you are on your biomedical journey and explain what your goals would be for a DAN Doctor visit.

Please share with the committee how you plan to fund ongoing treatment, since the TACA Family Scholarship Program is a one-time only grant.

Have you attended any of the following: DAN, USAAA or Autism One conferences or a TACA New Parent Seminar? If so, which cities and years did you attend?

All information submitted to TACA shall remain **confidential**. Please note that, pursuant to California and federal law requirements, TACA reserves the right to follow up to ensure any approved grant was actually used for its intended purpose.

I certify that the information on this form is true and complete to the best of my knowledge.

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Applicant Signature

Date

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Family Scholarship Program Application

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## CHECKLIST

### APPLICATION IS NOT COMPLETE WITHOUT THE FOLLOWING:

- Proof of diagnosis. (Need not be the entire evaluation, just the page with the child's name that confirms diagnosis.)
- Copy of current year to date pay stub for all household wage earners or most recent Tax Return.
- Date you became a TACA Member.
- Name, and date you started with, your TACA Parent Mentor.
- Completed summary of previous treatments and explanation of why you chose the DAN doctor you are requesting funding for.
- Contact information for DAN doctor.
- Cost breakdown – include estimates from DAN doctor.
- Explanation of Goals for your child's visit to a DAN Doctor.
- Explanation of how you plan to fund ongoing treatment, since the TACA Family Scholarship Program is a one-time only grant.

Please mail completed application to: TACA Family Scholarship Program, 3070 Bristol, Suite 340  
Costa Mesa, CA 92626

*TACA Family Scholarship Program – DAN Doctor Application – (Rev 7)*