TACA
TALK ABOUT CURING AUTISM
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Family Scholarship Program Application – Dr. Sears – Capistrano Beach, CA

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_____

Please list child's first name _____

Birth date _____ diagnosis if any_____

Please list child's first name _____
(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 2nd mortgage on your home: ❒ Yes ❒ No Monthly housing commitment 2nd 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 MAPS Doctor Scholarship)

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

Date you Joined TACA-USA Yahoo Group: _____ **(Required)**

TACA ASSSITANCE:

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: _____

_____

Proposal SUMMARY:

ON SEPARATE SHEETS OF PAPER PLEASE PROVIDE THE FOLLOWING:

This application is for an office visit and follow up appointment with Dr. Bob Sears. Any lab work or supplements ordered will be the patient's responsibility.

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 MAPS Doctor. Are you implementing biomedical intervention? If so, what have you tried so far? Are you working with a MAPS Doctor? If so, who?

Please make sure you have read the "Try Before You Apply" document that discusses how to get lab work and other items funded through insurance and even Medicaid.

Please make it clear to the committee where you are on your biomedical journey and explain what your goals would be for a MAPS 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: ARI, USAAA or Autism One conferences or a TACA Real Help Now Conference or Journey 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.

_____

Applicant Signature Date

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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 MAPS doctor you are requesting funding for.

❒ **Check here to agree to the following statement:** I understand that this scholarship is ONLY for an office visit and follow up appointment with Dr. Bob Sears in Capistrano Beach, CA. Any supplements or lab work ordered are my responsibility.

❒ Explanation of Goals for your child's visit to a MAPS 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, 2222 Martin Street, Suite 140 Irvine, CA 92612