Maximum Chances Funding Application

Date of Application			
Applicant's (Child's) Name			
Applicant Date of birth (MM/DD/YYYY)			
Primary Contact for Applicant			
Relationship to Applicant			
Street Address			
City	State	Zip Code	
Telephone			
E-mail Address			
Section 1: Applicant (Child) Information			
 Current Autism Spectrum /Asperger's Diagnosis _ Date of Diagnosis (Month/Year) Name of Diagnostician/Physician Proof of Diagnosis Attached □ 			

Section 2: Household Information

5. Please list the names of ALL of the applicant's family members, including parent(s) and dependents. Attach additional sheets if necessary.

Name Include parents, siblings, and other dependents (it is not necessary to include applicant)	Age	Relationship to applicant	ASD/ Asperger's Diagnosis (yes/no)

Section 3: Parent Information	
6. Child Lives with (both parents, mother, father, other):	
7. Which of the parent(s) are employed (both, father, mother, neither)?	
8. Is either parent active duty military? If yes, which branch of service?	
Section 4: Income Information	
9. What is your total family income as reported on your 2018 W-2 IRS tax form(s)?	\$
10. Please list any untaxed income for 2018 (eg child support, cash earnings, worker's compensation, or any other income not included on W-2).	\$
11. Are there any substantial changes to your current income relative to 2017 a please explain.	nd 2018? If yes,
Section 5: Description of Need Attach additional sheets if necessary.	
12. Applicant is requesting funding for services from☐ Therapeutic Strategies☐ Kotsanis Institute	
☐ Journey Learning Center - Specify program	
☐ White Bridle – Specify Session	 for the provider for
13. Have you incurred significant expenses to treat ASD/Asperger's that have no insurance or have you forgone treatments because they are not covered by your please explain.	
14. Please describe your current family situation, including any hardships that y relevant to this application.	

Section 6: Signature

With your signature you are confirming that you	have filled out this form completely and truthfully.
Parent or guardian signature	Date
Parent or guardian printed name	

Maximum chances will use the information that you provide to evaluate your request of assistance and determine our ability to provide assistance. We will not share your information with a third party outside of our organization other than as necessary to evaluate your request for assistance.

NON-DISCRIMINATION POLICY

Maximum Chances does not and shall not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin, disability, marital status, or sexual orientation, in any of its activities or operations. These activities include, but are not limited to, hiring and firing of staff, selection of volunteers and vendors, and provisions of services.

Please complete the form and mail to:

MAXimum Chances 4843 Colleyville Blvd. Suite 251-320 Colleyville, TX 76034

Please call 214-632-7739 or email nicole@maximumchances.org with questions.

Application Checklist

MAXimum Chances is only able to evaluate complete applications. Please submit paper copies of all information; MAXimum Chances cannot accept electronic copies. **No application will be considered until all of the following is submitted.**

Complete application (no questions left blank)
Autism diagnosis with name of diagnostician/developmental pediatrician clearly noted
Tax returns from 2 most recent tax years
Consent, Release, Waiver, and Indemnification Agreement (Consent Form link on website)