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

1. Current Autism Spectrum /Asperger's Diagnosis _____
2. Date of Diagnosis (Month/Year) _____
3. Name of Diagnostician/Physician _____
4. 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 this year's W-2 IRS tax form(s)?	$
10. Please list any untaxed income for this year. (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 this year & last year? If yes, please explain. _____

_____

_____

Section 5: Description of Need

Attach additional sheets if necessary.

12. Applicant is requesting funding for services from

- ☐ Kotsanis Institute
- ☐ Therapeutic Strategies
- ☐ Green Oaks School
- ☐ Journey Learning Center - Specify program _____
- □ Dr. Rios _____

Please ensure that you have read the "Cover Letter" on MAXimum Chances website for the provider for which you are requesting funding.

13. Have you incurred significant expenses to treat ASD/Asperger's that have not been covered by insurance or have you forgone treatments because they are not covered by your insurance? If yes, please explain._____

_____

_____

_____

14. Please describe your current family situation, including any hardships that you think are relevant to this application. _____

_____

_____

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_____

_____

_____

_____

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 wil 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 **MAXIMUMCHANCES@gmail.com** 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)