

Application – ESDM Autism Scholarship
Parent Coaching in the Early Start Denver Model (P-ESDM)
My Allie’s Place and Early Start Autism LLC

Application Number (Internal use only) _____

Website: myalliesplace.org. Review complete Terms and Conditions and see Open Enrollment dates on the autism website. An application may be submitted at any time and will be considered during a scheduled Open Enrollment period. Any scholarship awarded, of up to approximately \$4,000 per scholarship will be applied directly to cover costs of 14 parent coaching sessions conducted by a Board Certified Behavior Analyst who is also an ESDM Certified Therapist or ESDM Trained Therapist of Early Start Autism LLC using Telehealth. No scholarship sums will be paid to the scholarship recipient. Scholarship has no cash value.

(Rev. 04-02-24)

TO QUALIFY: Review complete qualifying requirements in Terms & Conditions on the website: myalliesplace.org.

- a. **The child *MUST* be 6-52 months of age at **END** of Open Enrollment period in which applying. An application for a child over 48 months and not more than 52 months of age may be considered as an alternate Applicant.**
- b. **Total current annual gross income of family household is limited to a maximum of \$250,000.00.**
- c. **Applicant *MUST* be child's Parent or Legal Guardian.**
- d. **Applicant *MUST* reply to email: ESDMscholarship@earlystartautism.com to accept or decline status as a Finalist or as an award Recipient within 48 hours of notification or scholarship may be forfeited.**
- e. **Applicant/Recipient *MUST* complete required forms before attending sessions: release, consent, waiver, pre-survey forms.**
- f. **Applicant/Recipient agrees to pay by an assigned deadline date the minimal fee (currently \$140) towards the \$4,000 cost of 14 parent coaching sessions.**
- g. **Since the Applicant/Recipient is actively coached with the child, Applicant/Recipient *MUST* agree that at least one Parent will attend all 14 sessions (with child) and the Applicant/Recipient themselves (with child) *MUST* attend a minimum of 12 sessions.**

1. **Child's date of birth (MM/DD/YYYY)**

____/____/____

2. **Child's sex assigned at birth:**

____ Male Female ____

3. **Child’s age in full months on May 1 or Oct 1 (at the **END** of Open Enrollment period in which applying).**

____ Months

4. **Does the child have a sibling or parent with autism?**

Yes ____ No ____

5. **Does the child have a sibling or parent with any other exceptionality or disability?**

Yes _____ No _____

6a. Is the child in foster care?

Yes _____ No _____

6b. If the child is in foster care, what is the foster parent's relationship to child?

_____ None _____ Grandparent _____ Aunt/Uncle _____ Sister/Brother Other: _____

7. Indicate whether the child has a diagnosis of autism. (A diagnosis of autism or being waitlisted is not required.)

Yes _____ No _____

8. If the child does not have a diagnosis of autism, is the child on a waitlist to be evaluated?

Yes _____ No _____

9. How many hours of therapy is the child receiving each week?

_____ 0 Hours _____ 1-5 hours _____ 6-10 hours _____ 11-15 hours _____ 16-20+ hours

10a. Enter the TOTAL number of people in the family household (including all adults and all children).

10b. Indicate ONLY the number of adults in the family household _____

10c. Indicate ONLY the number of children in the family household _____

11. Total CURRENT annual gross income of all members of the family

household: \$ _____

12. Total PRIOR YEAR annual gross income of all members of the family household:

\$ _____

13. Applicant agrees that all 14 sessions *MUST* be attended with the child and that Applicant themselves *MUST* attend with the child a minimum of 12 sessions.

Yes _____ No _____

14. Upon final acceptance, Applicant is expected to pay a nominal fee (currently \$140), a portion of the approximately \$4,000 cost of this P-ESDM scholarship. After Applicant completes the release, consent, waiver, pre- and post-survey forms and all 14 parent coaching sessions, some or all of the \$140 fee paid by Applicant will be refunded, contingent on availability of autism scholarship funds. Any additional fees paid for credit card charges are not refundable. Will Applicant commit to paying the \$140 fee in one lump-sum payment by the assigned deadline date?

Yes _____ No _____ If answer is No, please state the reason why the Applicant is unable to pay.

15. Briefly state the reason you wish to participate in this Early Start Denver Model autism scholarship program and also furnish any additional comments you wish to be considered.

16. Have you ever applied for an ESDM autism scholarship through My Allie's Place or Unicorn Children's Foundation?

Yes _____ No _____

17. Have you ever been selected to receive an autism scholarship through My Allie's Place or Unicorn Children's Foundation?

Yes _____ No _____

18. How did you learn of this ESDM autism scholarship? (Check all that apply.)

_____ **Website:** Enter website name or address: _____

- _____ **Email notice or invitation**
- _____ **Text Message**
- _____ **Social Media (Facebook, X, etc.)**
- _____ **Flyer**
- _____ **Physician/Physician's office**
- _____ **Support Group**
- _____ **Day Care Facility**
- _____ **Word of Mouth**
- _____ **FAU CARD Little Owls**
- _____ **Other:** _____

Name of Child: (Print)

First Name _____ **Last Name** _____

Applicant Name (MUST be child's parent or legal guardian):

Print: Applicant's First Name _____ Last Name _____

Applicant's Relationship to Child

_____ **Mother** _____ **Father** _____ **Legal Guardian**

Applicant's Primary Phone Number

Area Code _____ Telephone Number _____

Can this number receive text messages?

Yes _____ No _____

Secondary Phone Number

Area Code _____ Telephone Number _____

Can Secondary Phone Number receive text messages?

Yes _____ No _____

Applicant's Email

Confirm Applicant's Email

Applicant's Address _____

City _____

State _____

Zip _____

State County _____

Country United States

Additional Contact (A.C.) Name

First Name _____ Last Name _____

A.C. Relationship to Child

____ Mother ____ Father ____ Grandparent ____ Legal Guardian Other: _____

A.C. Primary Phone Number

Area Code _____ Telephone Number _____

Can A.C. phone number receive text messages?

Yes _____ No _____

A.C. Email

A.C. Confirm Email

By submission of this autism scholarship application, I acknowledge that I have read, agree to, and accept the entirety of the Terms and Conditions for the P-ESDM autism scholarship program on the website: myalliesplace.org. I agree to the use of electronic communications in the handling and processing of this application. Within 48 hours of notification, I agree to respond by email to ESDMscholarship@earlystartautism.com to accept/decline Finalist or Recipient status and if I accept, to provide any additional documentation required prior to the designated deadline. If I accept Recipient status, I agree to (1) pay the \$140 fee in one lump-sum payment (unless otherwise indicated in No.14 above), and to (2) sign and submit the required Release, consent, waiver, and pre-and post-survey forms. I agree to immediately notify by email to ESDMscholarship@earlystartautism.com any changes in my personal contact information, including email address, phone number(s), and home or mailing address, for myself and others listed on my Application.

Applicant's Signature:

Printed Name of Applicant: _____