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Generation Rescue
***Rescue Family* Application**

Generation Rescue's goal is to introduce and help facilitate early biomedical treatment by providing the necessary resources to individuals with Autism Spectrum Disorders and their families. Generation Rescue is proud to offer a grant program for treatments that may not otherwise be covered privately or by other third-party funding sources such as school districts, county programs, insurance, and/or other grant making entities. **This grant is only applicable for families who have not done biomedical treatment, with the exception of the GF/CF Diet.**

Applicants who meet the following grant program criteria and whose grant application is received by **May 31, 2010** will be considered for a *Rescue Family* grant. Since, in most cases, the applicant's parent or guardian will be completing the application, it is understood that the applicant will be the individual receiving the benefits of the grant.

***Rescue Family* Grant**

Generations Rescue's *Rescue Family* grants are designed to provide support to individuals and families affected by Autism Spectrum Disorders. Each grant recipient will receive 2-doctor visits with a specially trained physician who treats autism; vitamins, minerals and supplements for 90 days, a Generation Rescue *Rescue Mentor* and dietary intervention training.

Grant Guidelines

Applicants must:

- Provide proof of household Income
- # of dependants
- # of dependents with Autism Spectrum Disorder
- Information about what current funding the grantee is receiving (i.e. medical)
- Complete the ATEC survey on our website

- The following must be mailed to Generation Rescue in order to be considered for a *Rescue Family* grant:
  - Completed, signed and dated Grant Application
  - Verification of Diagnosis – Evaluation report or prescription from diagnosing physician
  - No more than 500 Word description of current family situation (descriptions exceeding this amount will not be considered)
  - Copy of previous years' tax return (no bank statements or check stubs will be accepted)
  - Completed ATEC survey - http://www.autism.com/ari/atec/atec-online.htm

- *Rescue Family* grant awards are based on economic need as defined by a percentage beneath the median income of a specific geographic area.
- Grant applications must be **received** no later than **May 31, 2010**.
- **Faxed or emailed grant applications will not be accepted**
- Grant applications must be mailed to:
  Generation Rescue Attn: Grant Committee 13636 Ventura Blvd #259 Sherman Oaks, CA 91423

The grant application deadline is May 31, 2010.
Incomplete grant applications will not be considered.

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***Rescue Family* Grant Application**

Today's Date: _____

How did you hear about Generation Rescue's *Rescue Family* Program? (Please list name if referred by a person)

General Information		
Applicant's Name (Child affected by Autism):		Applicant's Date of Birth:
Applicant's Current Age:		Applicant's Gender: ☐FEMALE ☐MALE
Street Address:		
City:	State:	Zip Code:
1) Guardian #1 Name:		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address: (required) You will be notified through this email.	
2) Guardian #2 Name:		Relationship:
Home Telephone Number:	Cell Number:	
Work Telephone Number:	Email Address: (required)	Child's Weight:

Dependant/Sibling Information			**Disorder/Diagnosis**
Name:	Age:	Relation to Applicant:	☐YES ☐NO Diagnosis:
Name:	Age:	Relation to Applicant:	☐YES ☐NO Diagnosis:
Name:	Age:	Relation to Applicant:	☐YES ☐NO Diagnosis:

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History

Consent: This form authorizes the use and/or release of the protected health information as noted below for purposes of the Generation Rescue grant review process. I give Generation Rescue permission to verify treatment information by contacting the treatment vendors directly. This authorization shall be valid for one year unless otherwise stated. I understand that I may revoke this authorization in writing at any time.

Signature/Date:

Current Diagnosis:	Date of Diagnosis:
Current Age:	Age at Diagnosis:
Name of Institution where Diagnosed:	Telephone Number:

Street Address:	City:	State:	Zip Code:

Treatments

Type of Treatment	**Treatment History** (please check one)	**Frequency** (ex: 2hrs per week)	**Provider of Services**
Speech Therapy	☐Current ☐Past ☐Not applicable		
Occupational Therapy	☐Current ☐Past ☐Not applicable		
Physical Therapy	☐Current ☐Past ☐Not applicable		
Applied Behavior Analysis	☐Current ☐Past ☐Not applicable		
Special Diets	☐Current ☐Past ☐Not applicable		
Biomedical Testing	☐Current ☐Past ☐Not applicable		
Biomedical Intervention	☐Current ☐Past ☐Not applicable		
Social Skills Groups	☐Current ☐Past ☐Not applicable		
Supplements	☐Current ☐Past ☐Not applicable		
Supplements	☐Current ☐Past ☐Not applicable		
Supplements	☐Current ☐Past ☐Not applicable		
Prescription Drugs	☐Current ☐Past ☐Not applicable		
Prescription Drugs	☐Current ☐Past ☐Not applicable		

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Financial Information

Guardian #1 Yearly Gross Income:	**$** *Please attach a copy of previous year's Tax Return**
Guardian #2 Yearly Gross Income:	**$** *Please attach a copy of previous year's Tax Return**
Other Sources of Income: (Regional Center, IHSS, SSI)	**$**
Total Yearly Gross & Other Income: *(no other income source will be accepted)	**$**

Funding Sources: (including other grants or scholarships awards)
Check all funding sources that apply and complete the requested information.

□ **Private/Health Insurance**		
Insurance Company:	Contact Person:	Telephone Number:
Treatments Covered:		
□ **Regional Center**		
Regional Center:	Contact Person:	Telephone Number:
Services Provided:		
□ **School District**		
School District:	Contact Person:	Telephone Number:
Services Provided:		
□ **County**		
County:	Contact Person:	Telephone Number:
Services Provided:		
□ **Other**		
Describe:	Contact Person:	Telephone Number:
Services Provided:		

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Please read each of the following statements carefully and initial if true.

____ 1. I understand that my child is required to follow the **GF/CF diet** or **SCD** diet for the 90-day grant period.

____ 2. I understand that a New Generation Medical Doctor (NGMD) will be assigned to my child and that I have no choice in this matter and cannot change the assigned doctor.

____ 3. I understand that a NGMD may consist of Medical Doctors, Chiropractors, Nutritionists, Nurse Practitioners, and other health professionals.

____ 4. I understand that I am responsible for scheduling my child's doctor appointments with the assigned doctor.

____ 5. I understand that if I miss my child's scheduled doctors appointment or cancel without giving 24hr notice, that I am responsible for any fees incurred.

____ 6. I understand that Generation Rescue will **not** be paying for any lab testing or blood work.

____ 7. I understand that Generation Rescue will **not** be paying for any supplements recommended by the NGMD.

____ 8. I understand that my child has **NOT** seen a Defeat Autism Now! (DAN!) or NGMD.

____ 9. I understand that my child has **NOT** done any lab testing.

____ 10. I understand that my child has **NOT** done any DAN! protocols for treating children with Autism.

I have read the above statements and fully understand each of them. I understand that by not complying with any of the above statements I forfeit my child's participation in the grant program. I will be held responsible for returning anything sent from Generation Rescue back to them at my cost.

_____ _____

Signature of parent/guardian Date

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Description of Family Situation

On a separate sheet of paper, please describe your current family situation in 500 words or less.

Disclaimer

If you are chosen for the *Rescue Family* grant program, you agree to the following:

- Implement ASD diet such as GF/CF or SCD
- Dropping out of the program once selected will make you liable for the following:
  1. All postage costs
  2. The fee(s) of 2(two) NGMD visits (estimated at $500.00)
- Document the child's progress through a daily journal and pre and post photographs or a Flip video camera that will be provided

I represent that I have read the preceding and completely understand the contents.

Parent/Guardian's Name: _____

Child's Name: _____

Signature of the Parent or Guardian: _____

Relationship to Child: _____

Date: _____

Address: _____

City: _____State: _____Zip: _____

Authorized Use of Name: ☐Yes ☐No

---------- **office use only** ----------

Application Received by Deadline	
Diagnosis Verification	
500 word Family Summary	
Copy of Previous Year's Tax Return Submitted	
Median Income for Zip Code	
ATEC Survey	

Generation Recue Grant Committee

☐Approved ☐Denied - Reason:

_____