adam morgan foundation

**FINANCIAL ASSISTANCE APPLICATION FORM**

**PLEASE NOTE THE FOLLOWING APPLICATION TERMS**

**a.** Applications must be on behalf of a specific child aged 3 and older at the time of the application who resides within St. Louis County and St. Charles County .

**b.** Funding is available only for families of a child affected by a Pervasive Developmental Disorder and must be for services/therapies/equipment deemed to benefit said child.

**c.** Documentation of the medical diagnosis from a medical professional is required.

**d.** Please complete a separate form for each child.

**e.** All financial information pertains to the parent/guardian of the applicant child. Please note that funding allocations of greater than $1,000 in a one (1) year period may require additional financial data, including tax returns, bank statements, pay stubs, etc.

**f.** The form must be signed by the parent or legal guardian of the child whom services are applied for.

**g.** Please complete this Application Form in its entirety, even if you have applied for funding from The Adam Morgan Foundation before, attaching extra pages as needed.

**h.** All information received is confidential and will not be released to any party without permission of the family and a signed release.

I. Applicant Details (information on the child services are requested for)

| | |
|---|---|
| **Child's Name:** | |
| **Child's Age:** | **Date of Birth:** / / |
| **Child's School(s):** | |

II. Family Information (information on parent(s)/guardian(s) of the above child)

| | | |
|---|---|---|
| **Parent/Guardian Name(s):** | | |
| **Address:** | | |
| **City** | **State** | **Zip** |
| **Phone Number:** | **Email:** | |
| **Best Time to Contact:** | | |
| **Marital Status:** ◯ Married/Cohabiting ◯ Single Parent ◯ Widowed ◯ Divorced/Separated | | |

Who referred you/how did you learn about The Adam Morgan Foundation?

## III. Services Requested

| | |
|---|---|
| **Service(s) Needed:** | |
| **Benefit(s) To Be Gained:** | |

If you currently work with an Organization/Company for Services, please include the information below.

| |
|---|
| **Organization Name:** |
| **Organization Address:** |
| **Organization Phone:** |
| **Contact Name:** |
| **Accreditation(s):** |

## IV. Financial Information

Parent/Guardian Financial Status

| | | |
|---|---|---|
| Total GROSS Earnings of Parents/Guardians | $ | Per ○ Week ○ Month ○ Year |
| Additional Income Benefits | $ | Per ○ Week ○ Month ○ Year |
| Disability | $ | Per ○ Week ○ Month ○ Year |

Parent/Guardian Employer Information

**Father/Guardian 1 Job Title:**

| | | | | | |
|---|---|---|---|---|---|
| **Employer:** | | | | | |
| **Address:** | | | | | |
| **City:** | | **State:** | | **Zip:** | |
| **Phone Number:** | | | | | |

**Mother/Guardian 2 Job Title:**

| | | | | | |
|---|---|---|---|---|---|
| **Employer:** | | | | | |
| **Address:** | | | | | |
| **City:** | | **State:** | | **Zip:** | |
| **Phone Number:** | | | | | |

| **Other Dependent Children:** | **Date of Birth:** |
|---|---|
| | / / |
| | / / |
| | / / |
| | / / |

Please explain any special circumstances pertaining to your financial situation, either temporary or long-term (i.e. medical bills, job loss, layoff, etc.):

V. Other Information

What other services/therapies has your child received, and what type of results were achieved?

What benefits will the funding of The Adam Morgan Foundation bring to your child and your family?

What time & day of the week would be best for you to meet with the Officers/Board Members of The Adam Morgan Foundation to discuss your child's needs and the availability of funding?

Please include any comments or other information you wish to share below:

I hereby confirm that I have provided within this Application Form all requested information to the best of my knowledge. I understand that failure to disclose full details or falsifying information could invalidate my Application and allow for further legal action by The Adam Morgan Foundation

| | |
|---|---|
| Name (printed): | |
| Relationship to Child: | |
| Signature: | Date: |

Please return completed application, along with any necessary documentation by fax or US Mail to:

The Adam Morgan Foundation
PO Box 532
St. Peters, MO 63376
Office: 636-447-ADAM (2326)
Fax: 636-447-2326 (please call before faxing)

Once your application has been reviewed, you will be contacted by a member of the Adam Morgan Foundation.
Thanks for your interest in The Adam Morgan Foundation!
* The Adam Morgan Foundation does not discriminate against individuals on the basis of race, color, sex, sexual orientation, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin in the administration of its funding.

FOR OFFICE USE ONLY

| Date Received: | | |
|---|---|---|
| | | |
| Via: | Review: | Contact: |
| | | |
| Interview Info: | | |
| | | |
| Other: | | |
| Notes: | | |