Autism Society of the Keys

19 Michael Drive, Key Largo Florida 33037
Phone: 305-942-5172 fax: 305-453-1650
501 (c) (3) non profit

Date of application: _____

Name of Applicant: _____ Age: _____ Male / Female

Address: _____

_____

How long have you resided in Monroe County? _____

Phone: _____

Email: _____

Who does applicant live with: _____
_____

Diagnosis: _____ Age of Diagnoses _____

Applicant's current school / work _____

If under 18, please give Parent/guardian information:

Name: _____

Address: _____
_____
Phone: _____
Email: _____
Current Work /School: _____

Are you currently in any therapy? If so please give details. (What types, duration, cost and place of service, etc.)

Have you ever been seen by or treated by a DAN doctor? If yes, please give details.

Are you currently doing any treatments, such as diet, supplements, chelation, HBOT, etc? Or do you wish to?

What sacrifices have you and/or your family made to seek treatment, care or therapy, if any?

What is your current financial situation? Please also list if you own a home and/or car.

What type of help are you seeking from the Autism Society of the Keys? Please include any details about cost, duration, and benefits of service. Please explain what impact it will have in your life?

Any award of services will be paid directly to a provider. Please list their information below.

Name of provider: _____
Contact Person: _____
Phone: _____
Address: _____

Have you requested or received funding or services from any other organization(s)?

Do you have health insurance that can help with treatments or therapies?

Would you like to become a member of ASK and be available to participate in fundraisers, awareness events, community projects that will help educated Monroe County resides? Would you be interested in donating your time or services, or be a contact available to speak and support new families with autism. If so please explain what you would be interested in doing.

Please share with us your story so far: your personal journey with autism, your hopes and any additional factors you would like us to consider.

All awarded services or monies will be given directly to a provider.

Please feel free to include any pictures of yourself, child or family.

Please include any printed material about a particular service or company, therapy or treatment.

You may also include any letters of references, from a friend, pastor, teacher or doctor for our consideration, although it is not necessary.

Please feel free to attach more paper if you need more room.

We will strive to decide on all requests within a 30 day period. However feel free to contact Jill Campbell if you have any questions about your request.
jillcampbell06@comcast.net or 305-942-5172