AUTISM SOCIETY

OF THE KEYS

171 Hood Avenue Suite #23
Tavernier, Florida 33070
Phone: 305-942-5172
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: ____

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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.)

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

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

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

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

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

Name of provider: ______________________________
Contact Person: _______________________________
Phone: ____
Address: ____
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Have you requested or received funding or services from any other organization(s)?
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Do you have health insurance that can help with treatments or therapies?
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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.
AutismSocietyoftheKeys@gmail.com or 305-942-5172