



Beyond the Limits
An Autism Resource Connection
...caring about children with autism

MONETARY GRANT PROGRAM APPLICATION

Applicants requesting monies from Beyond the Limits, An Autism Resource Connection (“Beyond the Limits”) must meet the following four qualifiers to be considered by the Beyond the Limits Grant Review Committee for a Monetary Grant.

1. The applicant(s) requesting funds must be a legal resident(s) of the State of Tennessee and parent(s)/guardian(s) of the child/children for whom the funds will benefit. Residency must be proven by including a copy of a valid and current Tennessee driver’s license and two paid utility bills along with the completed Monetary Grant Application Form.
2. The child/children for whom the funds will benefit must be diagnosed with an Autism Spectrum Disorder (“ASD”).
3. The Autism Spectrum Diagnosis must be made by a *Defeat Autism Now! (DAN!)* physician. Go to http://www.autismwebsite.com/practitioners/us_lc.htm to find the *DAN!* Physician Referral List.
4. A letter from your child’s *DAN!* Physician that states your child’s diagnosis and also states that your child will be under a treatment protocol for ASD.

The grant monies requested from Beyond the Limits are to help defray the costs of recently developed and recognized interventions in the form of tests, treatments, therapies, vitamin and mineral supplementation and traditional interventions (such as applied behavioral analysis, speech therapy, occupational therapy, physical therapy and others) for the treatment of ASD. Monies can or will be issued only if funds are available and authorized for this purpose by Beyond the Limits.

The Monetary Grant Program is not a one-time emergency grant program therefore parents/guardians can apply one year after the previous year’s application date.

NAME OF CHILD (whom you are applying for grant money)

LAST FIRST MIDDLE

AGE: _____ DATE OF BIRTH: _____

NAME OF CHILD (if you are applying for more than one child)

LAST FIRST MIDDLE

AGE: _____ DATE OF BIRTH: _____ *Page 1*

PARENT/GUARDIAN:

NAME: _____

STREET CITY ZIP CODE

PHONE: _____ EMAIL: _____

PARENT/GUARDIAN (if different than above):

NAME: _____

STREET CITY ZIP CODE

PHONE: _____ EMAIL: _____

DOCTOR INVOLVED IN CHILD'S TREATMENT:

NAME: _____

ADDRESS: _____

PHONE: _____

DOCTOR INVOLVED IN CHILD'S TREATMENT (if more than one doctor is involved):

NAME: _____

ADDRESS: _____

PHONE: _____

PARENT/GUARDIAN

SIGNATURE: _____

DATE: _____

PARENT/GUARDIAN

SIGNATURE: _____

DATE: _____

This monetary grant application cannot be considered until this form is completed, signed and all supporting documents are received.

Mail to: Beyond the Limits,
An Autism Resource Connection
P.O. Box 924
Hendersonville, TN 37077-924
ATTN: Grant Review Committee