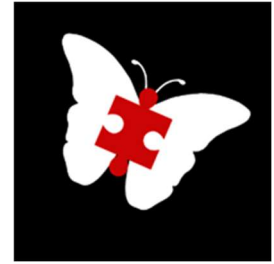


My Autism Ally Sensory Cuts Scholarship



Greetings,

This scholarship is open to individuals with a diagnosis of either autism spectrum disorder or sensory processing disorder that lives in northern Indiana.

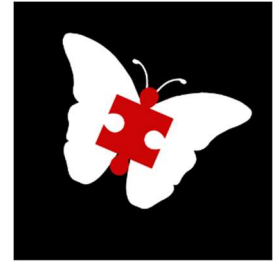
A few things to keep in mind.

1. If you qualify, you will receive 5 sessions at Sensory Cuts with the scholarship covering \$45 each session. **All participants must be able to schedule 5 Sensory Cut sessions within a 10-week time frame. Your co-pay will be \$5.00 per session which is due at the time of service.** If your child completes the program before using all five sessions, the remaining sessions are terminated to allow us to serve more individuals that need this scholarship. **Failure to attend a session without notifying Sensory Cuts in advance will result in your scholarship being revoked.**
2. Send your completed application to My Autism Ally by email to info@myautismally.org or by mail to My Autism Ally - PO Box 15- Huntertown IN, 46748
3. The Diagnosis Verification can be filled out by any current provider of services that the individual that is receiving the haircut scholarship participates. This includes but is not limited to; ABA centers, outpatient therapy clinics, First Steps providers, local public schools, Case Management companies, Medicaid waiver service providers, Vocational Rehabilitation providers, family physician, diagnostician, mental health practitioners.

If you have questions, please reach out to us at info@myautismally.org or call 260-207-4686.

***Application is on the back**

My Autism Ally Sensory Cuts Scholarship Application



Name _____

Address _____

City _____ State _____ Zip Code _____

Age of individual receiving getting haircut _____ Male _____ Female _____

Email _____

Phone _____

How long have you lived at this address? _____

Number of people living in the household: Adults _____ Children _____

What was your approximate household income last year? _____

Participant expectations:

- All participants must be able to schedule 5 Sensory Cut sessions within a 10-week time frame.
- All scholarships have a \$5.00 participant co-pay due at the time-of-service payable to Sensory Cuts.
- Failure to attend a session without notifying Sensory Cuts in advance will result in your scholarship being revoked.

You will receive 5 sessions at Sensory Cuts. Your co-pay will be \$5.00 per session and the scholarship will pay the remainder of the payment. If your child completes the program before using all five sessions, the remaining sessions are terminated to allow us to serve more individuals that need this scholarship.

I understand the conditions and expectations of the program and the information I have submitted is accurate.

Parent Signature _____

Sensory Cuts Scholarship Diagnosis Verification

To whom it may concern,

You are being asked to provide verification that the individual named above is being treated by your facility/agency for a diagnosis/evaluation of: Choose one

_____ Autism

_____ Sensory Processing Disorder

Agency/Facility Name _____

Email _____

Phone Number _____

Printed Name of agency/facility representative _____

Signature of agency/facility representative _____