



S2C Speller Access Fund Application

Please completely review all of the following information before filling out this application. Please print clearly and provide all required information. Illegible and incomplete applications cannot be considered.

I-ASC's S2C Speller Access Fund provides qualifying individuals with the following:

- Set of stencil letterboards
- 2 workbooks
- 5 sessions with a registered S2C Practitioner participating in the Speller Access Fund Program

Qualifying applicants are individuals who are nonspeakers, minimally speaking, or unreliable speaking. Funding for this program is limited. It is intended only for families in need of financial assistance who are otherwise unable to obtain access to Spelling to Communicate (S2C) and is open to US or International individuals.

Eligibility Requirements

You must meet the following criteria to apply:

- The individual you are applying for must be 7 years of age or older.
- Only parents or legal guardians may apply on behalf of their child/adult.
- A Communication Regulation Partner (CRP), which is an adult who is committed to learning and helping the individual to effectively use Spelling to Communicate and must be available several days a week. Understand that an S2C Practitioner will get you started and support you along the way, but the work is done at home. Only with repetition and practice will S2C be successful.
- Contact I-ASC to locate an S2C Practitioner for you to work with. Email info@i-asc.org for information on an S2C Practitioner near you.



Please initial each line indicating your agreement:

_____ I agree that I or an appointed individual will be a committed CRP for my child/adult.

_____ I understand that these funds are dispersed directly to an I-ASC registered S2C Practitioner of my choice to be used only for our S2C sessions.

_____ I confirm that I have chosen an S2C Practitioner by reaching out to info@i-asc.org for information on S2C Practitioners.

_____ I understand that I cannot apply for funding to pay for already-completed sessions with a practitioner. This fund is for future appointments only.

_____ I understand that I-ASC is not able to provide funding for travel expenses to see a practitioner.

_____ I agree to complete a follow up survey with I-ASC one year after receipt of the funds.

NONSPEAKING CHILD/ADULT

Full Name: _____ Age: _____ Date of Birth: _____

What is your relationship to the nonspeaker? _____

PARENT(S)/LEGAL GUARDIAN(S)

Full Name(s): _____

Marital Status: _____ Telephone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Country: _____ Telephone: _____

Employer: _____

Total annual income of family living in the home: \$ _____



Please comment on how the speller will be supported at home through the process of learning S2C, why you think your nonspeaker will benefit from S2C, any prior experience using letterboards they may have had, and other considerations you would like us to know about.

Your Access Fund S2C Practitioner you will be working with:

Name: _____

Phone: _____

Email: _____

Location: _____

Child or Adult's Official Diagnosis: _____

What is the person with Autism's ability to use verbal communication? (Circle One):

Nonspeaking (No speech)

Minimally Speaking (Some words & phrases)

Unreliably Speaking (Speech is not effective for robust communication)

How does the person currently communicate? _____



Is he/she at risk of bodily harm to self or others? Please explain below. _____

What therapy or intervention have you tried in the past? _____

Please share any other information that would be useful for the S2C Practitioner to know.

SUPPLEMENTAL SECURITY INCOME (SSI) \$ _____

Personal Statement of Income and Financial Status of Custodial Parents or Guardians

ASSETS

Checking Account \$ _____

Savings Account \$ _____

Real Estate \$ _____

Home Value \$ _____

Automobiles \$ _____

Personal Property \$ _____

Stocks/IRA/Etc \$ _____

Total Assets: \$ _____

MONTHLY LIABILITIES

Monthly House Payment/Rent \$ _____

Other Monthly Bills/Loans \$ _____

Monthly Utilities \$ _____

Monthly Insurance \$ _____

Monthly Automobile Expenses \$ _____

Monthly Medical Bills \$ _____

Physician/Agency \$ _____

Total Monthly Liabilities: \$ _____



Combined sources of income:

Attach a copy of your most recent tax return. (Main form only - do NOT send attachments/schedule)

INCOME TYPE	MONTHLY	ANNUAL
Salary:	\$ _____	\$ _____
Bonuses & Commissions:	\$ _____	\$ _____
Alimony/Child Support:	\$ _____	\$ _____
Real Estate Income:	\$ _____	\$ _____
All Other Income:	\$ _____	\$ _____
TOTAL INCOME:	\$ _____	\$ _____

(ALL OTHER INCOME includes Grants, Social Security, CRS, Medicaid, etc.)

By signing below, I attest that all information is truthful and accurate. I grant my permission to I-ASC to contact the clinicians listed for verification. I understand that providing false information will immediately disqualify my application and any future grant opportunities from I-ASC.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Email completed application to: info@i-asc.org
 Or Mail to
 International Association of Spelling as Communication
 722 Grant Street, Suite C
 Herndon, VA 20170