THE HALLMAN-HAINES FOUNDATION
FOR AUTISM & SPINA BIFIDA

January 31, 2019

The Hallman-Haines Foundation for Autism & Spina Bifida was established May of 2011. As parents of children/adults with both of these disabilities we felt that there was a need to help others going through and dealing with some of the same issues we have encountered.

Our Mission is to raise money to help support individuals and families living with autism and/or spina bifida. Monies raised will also help support organizations involved with improving the lives of people/families with autism and/or spina bifida.

The monies raised will be given out as grants for therapies, medical equipment, camps, community lessons (swimming, cooking...), educational and sensory tools to individuals who have autism and/or spina bifida.

Our end goal is to improve the lives of children and adults with autism and/or spina bifida so that they can have the same quality of life as everyone else. Through financial grants the "Hallman-Haines Foundation" is looking to give those individuals receiving the grants an opportunity they may not otherwise have.

The "Hallman-Haines Foundation" through its fund raising activities last year was the proud recipients of monies raised during its annual motorcycle run for which Haines & Kibblehouse, Inc., was the main sponsor. With the monies raised, the Hallman-Haines Foundation is currently awarding grants of up to $500.00. If you are interested in applying for a Grant, please see the attached grant application and instructions. Grant applications must be received on or before May 20, 2019.

Sincerely,

Hallman-Haines Foundation

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The Hallman-Haines Foundation is pleased to announce grants for children/adults with Autism and/or Spina Bifida. These grants are for up to a maximum amount of $500.00 each and will be made available to qualified applicants while funds remain available for this program. Funds for this Grant Program are, however, limited and this Grant Program may be discontinued at any time.

ONE CHECK OR PURCHASE PER APPLICANT.

Applications will be reviewed:

- based on the date received by the Hallman-Haines Foundation.
- if a grant was received in a prior year.
- completion of the grant application

APPLICATIONS MUST BE IN BY: May 20, 2019-
MAIL TO:
HALLMAN-HAINES FOUNDATION
210 GREEN TOP ROAD –
SELLERSVILLE PA 18960

The following activities, support and equipment are eligible for funding that occurs from January 1, 2019 and August 31, 2019:

- Summer camps
- Therapies :
  Physical Therapy * Occupational Therapy * Speech Therapy * Music Therapy
  Therapeutic Horse Back Riding * Sensory Therapies * Social Skill Groups
- Community programs :
  Swimming lessons * Karate lessons * Dance Lessons * Art Lessons * Cooking Lessons
- Equipment:
  Educational software * IPad * Educational Apps * Computer * Adaptive Computer Equipment for Computer * Talker *

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Sensory Equipment (Example: Trampoline – weighted blanket, etc..)* Wheelchairs * Walkers * Canes

Grant Requirements:

Each child/adult must have a script from their doctor with:

- Doctor's name, address and phone number
- Child/Adult's name (first and last names)
- Diagnosis of Autism and/or Spina Bifida
- Doctor's signature

A Brochure or Camp registration must be filled out and attached.

If this is a reimbursement, please attach a copy of the bill or invoice showing that it was paid.

If grant application is not filled out in its entirety or missing information or support it will not be processed. If you are considering a reimbursement for anything there must be a paid in full receipt included in application.

Example: if you are purchasing an Ipad a copy of the receipt must be included with application.

The Hallman-Haines Foundation would like to fulfill as many grants as possible. Please remember that not all grants will be fulfilled.

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Application for Grant 2019:

A: Person who Grant is for:

Name of Person Grant is for:	First Name:	Last Name:	
Age of Person As of January 1, 2019	Month	Year	Age
Diagnosis:			

B: ** Person Applying for Grant:

Name of Person Applying for Grant:	First Name:	Last Name:	
Relationship to person Grant is for:	☐ I am filling out form for myself	☐ Grandparent	
	☐ Parent/ Step Parent	☐ Legal Guardian	
	☐ Sibling	☐ Other (please specify)	
Mailing Address:	Street:		
	Street #2:		
	City:	State:	Zip:
Phone Number:	Day Time:	Evening:	
Email			

****Person applying for grant must be 18 years or older, parent, legal guardian or adult applying for self.**

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C. Please complete for all therapies/activity requests:

Therapies or Activities:

Eligible Therapy/Activity *See Section C directions*	Make Check Payable to: Name of Organization providing Therapy/Activity	Cost of Therapy/Activity	Date(s) of Therapy/Activity **Must be between Jan. 1, 2019 and Aug. 31, 2019*	Included documentation showing cost of Therapy or Activity	Included is a copy of a **PAID** receipt
Example: Physical Therapy	*123 PT*	*$300.00*	*7/23/2019 thru 8/31/2019*	✓ Yes	☐ Yes ✓ No
1.				☐ Yes	☐ Yes ☐ No
2.				☐ Yes	☐ Yes ☐ No
3.				☐ Yes	☐ Yes ☐ No

Equipment/ Educational

Eligible Equipment & Educational *See Section C directions*	Make Check Payable to: Equipment or Educational Provider	Cost of Equipment or Educational	Date(s) purchased **Must be between Jan. 1, 2019 and Aug. 31, 2019*	Included documentation showing cost of Equipment or Educational	Included is a copy of a **PAID** receipt
Example: IPAD	*Best Buy*	*$499.99*	*7/23/2019 thru 8/31/2019*	✓ Yes	✓ Yes ☐ No
1.				☐ Yes	☐ Yes ☐ No
2.				☐ Yes	☐ Yes ☐ No
3.				☐ Yes	☐ Yes ☐ No

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D. Verification of information:

I agree and confirm the following:

- I am an adult with Autism and/or Spina Bifida or an adult (over 18 years old) and a family member or guardian with full legal authority to complete this application on behalf of the applicant who has Autism and/or Spina Bifida and for whom the Grant is sought.
- I do hereby release, waive, discharge and covenant not to sue the Hallman-Haines Foundation for Autism & Spina Bifida for any and all liability from any and all claims, injuries and/or damages to person or property arising from or connected in any way with any Grant the Applicant may receive and/or that may occur or be sustained during the course of activity or therapy in connection with this Grant. I make this release, waiver, discharge and covenant not to sue on behalf of myself and any applicant for whom I am the family member and/or guardian.
- I hereby certify that the information provided is true and correct.
- I understand that if I am eligible, my grant may be terminated if I have made false statements in this application.

_____ _____

Signature of Person Completing Application **Date**

E. Doctor's Verification:

Attached is a copy of a doctor's script stating the child/adult has Autism and/or Spina Bifida. Please refer to grant cover letter to see what is required on doctor's script. Please attach to application.

FOR OFFICE ONLY:

Date Postmarked:	☐ Eligible	Comments:
	☐ Ineligible	
	☐ Pending	