



“i-Care” iPad Application Form

Please review the following information before filling out the application.

Applications will be reviewed in the order in which they are received.

What are the eligibility requirements?

1. Individual you are applying for must have an ASD Diagnosis.
2. Applicant must reside in Pike County, PA.
3. Parent should have basic computing skills
4. Parent must have access to a computer, the Internet and an Apple iTunes account.

What are the Restrictions and Stipulations?

1. One iPad or AAC Software Application (APP) per family, per Calendar year.
2. There are no age restrictions.
3. There are no income restrictions.
4. Parent must provide documentation confirming applicant's diagnosis.
5. Parent must provide a goal statement indicating how applicant will benefit from iPad or Software/Apps.
6. Pike Autism Support Services is not responsible for damage/repair or Setup of devices or applications.
7. Parent must agree to attend an iPad Training if offered.

How do you apply for the iPad or Software App?

1. Provide recommendation Letter from a Teacher, Therapist, SLP or Doctor or
2. Provide recommendation from PASS Board member and
3. If you meet the eligibility requirements, complete the iCare Application Form.

How long until I know if my application has been approved?

1. You will be informed when your completed application has been received by our Board of Directors.
2. Review of the application will typically be done within 30 days of receipt.
3. Award and distribution of iPad's and Software App's is at the sole discretion of Pike Autism Support Services and is based upon availability of devices and adequate funding to purchase them.



i-Care Application Form

Applicant Name: _____ **Age:** _____ **Date of Birth:** _____

I am requesting an iPad iPod ProLoQuo2Go App G.A.I.T. Scholarship Other _____

Diagnosis / Disability: (please attach report) _____

Please provide the following information:

Mother's Name: _____ **Phone:** _____

Street/City/Zip: _____

Email Address: _____

Father's Name: _____ **Phone:** _____

Street/City/Zip: _____

Email Address: _____

Number and ages of other dependent children: _____

Overview of Applicant's Communication Challenges: _____

Name of Diagnosing Doctor: _____

Address: _____ **Phone:** _____

Street/City/Zip: _____

Email Address: _____



Pike Autism Support Services

Support & Advocacy for North East Pennsylvania

www.pikeautism.org



Eligibility Questions:

1. Does the applicant reside in Pike County, PA. [] Yes [] No
2. Does Parent have basic computing skills? [] Yes [] No
3. Does Parent have access to a computer, the Internet and an iTunes account? [] Yes [] No
4. Do you agree to release photos and/or videos for PASS promotional use? [] Yes [] No
5. Do you agree to attend an iPad Training if offered by PASS? [] Yes [] No

Please provide a "Goal Statement" indicating how applicant will benefit from using an iPad or AAC Software requested:

Referral Information:

How did you become aware of the PASS iCare - iPad Program? _____

I have a recommendation Letter from a: [] Teacher [] Therapist [] SLP [] Doctor [] PASS Board member

Please provide the name of person that provided letter: _____

Please mail completed application, diagnosis documentation and Recommendation letter to:

Pike Autism Support Services
 Milford Community House
 201 Broad Street Suite #4, Milford Pennsylvania 18337
Attention: i-Care Application

The above information is freely given to process this application request. By signing, I attest that all information included is true and accurate and give Pike Autism Support Services permission to contact my child's medical professional listed to verify and discuss diagnosis and speech abilities. I understand that falsifying information will immediately disqualify this application. I understand that the iPad is to be used primarily as a communication device for the applicant

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

This application cannot be considered until this form is completed, signed and all supporting documentation is received. The information included in this application is confidential and for the sole use of Pike Autism Support Services. Please keep a copy for your records.

Email any questions to info@passnepa.org

Date Approved	Approved By	Device	Purchased on	Vendor	Gifted on

Milford Community House, 201 Broad Street Suite #4, Milford Pennsylvania 18337

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www.pikeautism.org