

**Autistic Children's Support Group of Worcester County, Inc.
Funding Support Application**

Date of Request: _____

Child's Name & Address: _____

Parent/Guardian Name: _____

Diagnoses: _____

Phone Number: _____ Child's Birthdate: _____

Funding request

Briefly explain the reason the individual is in need of support funding:

Amount Requested: _____

What other resources have been attempted or exhausted?

Requested by: _____ Phone Number: _____

Name and Address for where the payment is to be sent (separate form may be attached if necessary):

***Include invoice if possible**

Please mail this form to The Autistic Children's Support Group of Worcester County
Attn: Funding Request
PO Box 1322
Ocean Pines, MD 21811

Thank you.

This completed form may also be emailed to acsgwc@gmail.com