



Serving Children with Autism and Developmental Disabilities

314 Broad Street Suite B, Lake Charles, LA 70601

Application for Tuition Assistance

The St. Nicholas Center for Early Intervention recognizes that finding funding for therapy is difficult. To assist families who desire ABA therapy for their child and whose insurance limits coverage, a sliding fee scale is available. A sliding fee scale ranges anywhere for \$25.00 to \$50.00 per hour for one on one therapy.

All information required for application will be considered confidential.

-PLEASE FILL OUT THE ENTIRE APPLICATION.

-ATTACH A COPY FOR YOUR 2010/2011 U.S. INDIVIDUAL TAX RETURN/FORM 1040, W2, or 1099

NAME OF FAMILY _____

STREET ADDRESS _____

MAILING ADDRESS _____

CITY _____ STATE _____ HOME PHONE (____) _____

FATHER'S OCCUPATION _____ WORK PHONE (____) _____

EMPLOYED BY _____ YEARS EMPLOYED _____

MOTHER'S OCCUPATION _____ WORK PHONE (____) _____

EMPLOYED BY _____ YEARS EMPLOYED _____

STATUS OF CHILDREN IN FAMILY

	<u>NAME</u>	<u>GRADE IN 2010-2011</u>	<u>SCHOOL</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

The financial information requested below will be held in strict confidence.

What is your expected gross income for the next 12 months? _____

(Please include wages, alimony, child support, and any other income)

Number of automobiles owned by family: _____

(Please include Make/Model/Year)

- 1. _____ Financed: _____ Monthly Payments: _____
- 2. _____ Financed: _____ Monthly Payments: _____
- 3. _____ Financed: _____ Monthly payments: _____

If any of the above automobiles are financed, please indicate with whom:

Does the family own a home: ___ Yes ___ No (if no, amount of monthly rent) _____

Monthly Mortgage Payments: \$ _____

Mortgage Company: _____

Does your child take Dance, Karate lessons, ECT.? Please list below

NAME OF CHILD	TYPE OF ACTIVITY	COST PER MONTH
1.		
2.		
3.		
4.		
5.		

Other fixed monthly obligations: (ex. Speech, OT, PT, Sensory Int., Monthly club meetings, ETC)

NAME	PURPOSE	MONTHLY PAYMENTS	BALANCE OWED
1.			
2.			
3.			
4.			
5.			

ATTACH AN EXTRA SHEET IF NECESSARY

ANY OTHER INFORMATION WHICH THE APPLICANT FEELS THE TUITION ASSISTANCE COMMITTEE SHOULD KNOW REGARDING THIS APPLICATION:

ALL TUITION ASSISTANCE IS FOR ONE YEAR ONLY. A NEW APPLICATION FOR TUITION ASSISTANCE MUST BE COMPLETED EACH YEAR.

Signature of Father (Guardian)

Date

Signature of Mother (Guardian)

Date

FOR OFFICIAL USE ONLY:

DATE APPLICATION APPROVED _____

AMOUNT APPROVED _____

SIGNATURE OF APPROVING AGENT _____