CYNTHIA NORALL
FOUNDATION

To inspire and empower people affected by autism spectrum disorders by celebrating and honoring their unique differences. To educate, inform and enlighten the public to the benefit of these unique individuals; simply, to remind us all that "special is better than perfect."

Grant Application

Please read the following criteria before completing the following request form.

The Cynthia Norall Foundation funding decisions are based on several factors, including: urgency, financial need, eligibility and available funding. All submissions will be reviewed by The Cynthia Norall Foundation. You will be contacted within 30 days of receipt and all decisions are final.

The Fund Program will award an annual grant for the benefit of the awarded applicant in each of the following three areas:

- Social / Behavioral
- Education / Community Awareness
- Therapeutic Supports

Eligibility Guidelines

Applicant(s) must:

- Live within San Diego County, California, United States.
- Provide The Cynthia Norall Foundation with a concrete plan for how current and future needs are to be met.
- Must have an income less than the US Median for the state.
- If approved, the applicant must agree to provide photos and updates to The Cynthia Norall Foundation by signing a photography and media release.
  Accept payment from Hoaloha Foundation within but no later than 30 days services are completed.

APPLICATION

Please complete all fields to be considered.

Contact (first & last name):_____
Relationship to applicant:_____
Residential Address:_____
City, State, Zip:_____
Mailing Address (if different):_____
City, State, Zip:_____

Contact Phone:_____
Contact Email:_____

Have you ever received funds from The Cynthia Norall Foundation or Hoaloha Foundation?
Yes No
If so, when?_____

How did you hear about us?_____

Applicant (first & last name):_____
Diagnosed condition:_____
The applicant in need of funds must be diagnosed with an Autism Spectrum Disorder. This must be verifiable by education records or medical paperwork.

Age of applicant/ date of birth:_____

Gender: Male Female

Age at diagnosis:_____

Describe the financial hardship need. Include a description of the existing or current services, how long these services have been provided and any ongoing benefits being received by Applicant.

_____
_____
_____
_____
_____

Indicate the specific service needed, the urgency of the treatment or support and any follow-up required.

_____
_____
_____
_____

1. Facility and/or Service Provider that will provide services for the application:
Provider:_____
Address:_____
Phone:_____Fax:_____
Website:_____

What is the estimated total cost of services?
$_____

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(If applicant needs to submit more than one service provider, please attach to this form.)

How much are you able to contribute?
$_____

Have you applied for care through your medical insurance medical health coverage? Yes No
Date:_____
Result of financing request: Approved Declined

How much have you received from other funding sources?
$_____

Describe your personal current financial hardship.

_____

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Complete all fields to be considered. Incomplete applications will not be considered.
Once completed please email: grants@cynthianorallfoundation.org

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