AUTISM SOCIETY

Improving the Lives of All Affected by Autism

Kern Autism Network

SCHOLARSHIP REQUEST
2014

First Name: _____

Last Name: _____

Phone Contact: _____

Email Address: _____

Address: _____

City/State/Zip: _____

Client of Kern Regional Center: yes no SC Name: _____
Diagnosis of Autism: yes no
Age of Recipient: _____ Proof of diagnosis must be attached to this form.

Activity Request for Scholarship: _____

_____

Name of Event: _____

Date of Event: _____

Amount of Scholarship Approved: _____ (KAN to fill in)

Note: Recipient will be contacted once Kern Autism Network receives the completed form. All scholarships are based on diagnosis of autism and financial need. All monies will be paid directly to the agency providing the service. A copy of the original event details must be attached to this form. Fax forms to: 661-588-4235 or scan the forms via email.

KAN: 1/2013