



## EDUCATION & TRAINING SPONSORSHIP REQUEST FORM

Parent Name:		Child's Name:		Child's DOB:	
Address:					
City:		State:	Zip Code:		Center Provider/Doctor:
Telephone:			Email:		
Child's Diagnosis:			Is your child a patient of The Center?    Yes    No		

For which program are you requesting financial assistance?

Date of Program: \_\_\_\_\_

<input type="checkbox"/> Advanced Problem Behavior Class	<input type="checkbox"/> Get the Most of Your ABA	<input type="checkbox"/> Sleep Time & Morning Routines
<input type="checkbox"/> Autism 101	<input type="checkbox"/> Health, Hygiene, & Puberty	<input type="checkbox"/> Special Education/F.A.S.T Program
<input type="checkbox"/> Feeding & Mealtime Challenges	<input type="checkbox"/> Managing Tantrums & Meltdowns	<input type="checkbox"/> Other

Have you previously applied for a sponsorship from The Center?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is your current monthly household income?	Household size:	
Does your child have Medi-Cal or CalOptima Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In order to maintain the sponsorship program and continue providing support to as many families as possible, we ask families to contribute to the extent that they are willing and able. <b>Please indicate how much you will be contributing toward the registration fee. <i>This amount does not determine the final fee of the program.</i></b>	\$ _____	

Why are you interested in attending this program, and what do you believe will be gained by attending?

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Why are you requesting financial assistance?

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By signing this Sponsorship Assistance Form, I agree to allow my family's name to be used to express appreciation to the sponsor.

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Once we have received your application, our Training Coordinator will contact you and let you know the status of your status. **All requests are to be submitted to the training department no later than one week prior to the date of the program.** Please email the completed form to [centertraining1@uci.edu](mailto:centertraining1@uci.edu) or fax it to 949-221-0004 Attn: Training.

FOR USE OF THE CENTER ONLY

Eligibility: Reduced \_\_\_\_\_ Full \_\_\_\_\_ Denied \_\_\_\_\_

**Amount Due:** \_\_\_\_\_ **Paid:** \_\_\_\_\_

Determining Staff Person's Signature: \_\_\_\_\_ Date: \_\_\_\_\_