

Persons in Need (PIN) Application

Year 2006

Kitaro Watanabe Fund

- Benefit to child 17 years of age or younger.
- Child has a serious medical condition or special education needs.
- Preference will be given to families with longstanding residence in the State of Hawaii.
- Preference will be given to children for whom onetime funding assistance will significantly affect their ability to recover from their problem and will facilitate their return to a productive life.
- Preference for child(ren) in need, including child(ren) in poverty or gap group.

Please **PRINT**. The entire application must be completed to be considered. Please note that although these funds are not a source of emergency funding, every effort will be made to respond in a timely manner.

There is no set deadline for submission of applications. Applicants should be aware that awards are made as funding is available.

PART I

Child's Name: _____

Address: _____

City/State _____ Zip: _____

Child's Birth date: _____ Sex: _____ Years of Residence in Hawaii: _____yrs

Please check the following:

The child has serious medical needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The child has a disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The child has special education needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The child previously received/benefited from a PIN grant	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PART II

Name of person submitting this application: _____

Address: _____

Home Phone: _____ Work Phone: _____

Place of Employment: _____ Occupation: _____

PART III - PURPOSE OF FUNDS

Purpose of requested funds: _____

Total amount requested: \$ _____ Date funds are needed: _____

PART V - SOCIAL SUMMARY (Required)

Name of Referring Agency: _____

Agency Address: _____

Please provide a social summary, which describes the applicant and relevant background information, which further explains the problem or need. State what alternatives have been pursued and the outcomes. Describe the desired goal. Any unusual circumstances should be explained in this section.

NOTE: This section must be completed by a community professional - for example: social worker, pastor, teacher, psychologist, etc.

The information given above is true and correct to the best of my knowledge.

Signature of Parent or Guardian

Date

Signature of Referring Agency

Date

Please return application and all attachments to:

Learning Disabilities Association of Hawaii
200 N. Vineyard Blvd., Suite 310
Honolulu, Hawaii 96817