NeuroAlly Family Fund
Awareness | Empathy | Health

(719) 722-0500
tracy@nafamilyfund.org
www.nafamilyfund.com
15085 Vollmer Rd, Colorado Springs, CO 80908

Candidate Family Questionnaire (Diagnoses) A.2

The mission of NeuroAlly Family Fund is to see neurodivergent individuals and families living happy, healthy, and productive lives and to provide a financial bridge and a spectrum of creative solutions that foster awareness, empathy, and healthy interactions for neurodivergent individuals and families.

In order to do that, we need some information about your family. All information provided will be kept confidential in accordance with HIPAA regulations. Thank you for your time and willingness to share!

Family Introduction

1. How many members in your family are seeking a diagnosis or evaluation?

2. What are the ages and genders of the individuals seeking diagnoses or evaluations?

Neurodivergence Concerns

3. Which family member(s) do you suspect may be neurodivergent (e.g. spouse, child)?

4. What behaviors or challenges have led you to believe there may be neurodivergence? Please provide three specific examples, including where and when the most problematic or challenging behaviors are observed.

5. How long have you observed the behaviors or challenges you just described?

Diagnosis Needs

6. What type(s) of neurodivergent evaluation are you seeking (e.g. Autism Spectrum Disorder (ASD) evaluation, ADHD evaluation, etc.)?

7. How would diagnosis support both the family member for whom you are seeking an evaluation and the rest of your family at this time?

(719) 722-0500
tracy@nafamilyfund.org
www.nafamilyfund.com
15085 Vollmer Rd, Colorado Springs, CO 80908

Financial Considerations

8. Does your current insurance plan cover any portion of neurodivergent evaluation? If so, what percentage or amount does your insurance cover?

9. How would receiving financial assistance for diagnoses from NeuroAlly Family Fund impact your family?

10. Are you willing to sign a contractual agreement that NeuroAlly Family Fund will pay the diagnostic provider directly on behalf of your family and give you a receipt?

Other Information

11. Is there any additional information that you would like to share about your family at this time?

12. How did you hear about NeuroAlly Family Fund?

CONTACT INFORMATION:

First Name:
Last Name:
Email:
Phone:

By signing this document, I declare that the information provided is accurate and complete:

_____ _____

Signature Date