

Developmental Disabilities Services  
**Autism Family Support Grant**  
Payee Assurance

I/We \_\_\_\_\_ assure that if the Autism Family Support Grant request for  
(Name of Payee)  
\_\_\_\_\_ is approved by DDS to purchase

\_\_\_\_\_  
Name of Service or Item(s)

**(Initial all that apply)**

\_\_\_\_\_ I will purchase the items, fees, deposits, or services only for the individual for whom the funds were approved.

\_\_\_\_\_ I will obtain receipts for any items, fees, deposits, or services that are equivalent to the amount received for the approved purchase and provide them to the DDS Service Coordinator.

\_\_\_\_\_  
(Name of Service Coordinator)

\_\_\_\_\_ I will ensure that all purchased items remain with the individual and/or the guardian, and may not be used by or for any other person or agency.

\_\_\_\_\_ I will return any unused balance of funds to DDS in the form of a check or money order made payable to DDS, identifying the recipient of funds and mailed to the Program Administrator, DDS, Slot S-380, PO Box 1437, Little Rock, AR 72203-1437.

**I am aware that the Autism Family Support Grant is a special program available one time only.** I am also aware that failure to abide by the terms of these assurances will cause DDS to disallow me from being a payee for any future Division of Developmental Disabilities Services Special Needs Program requests.

Signed: \_\_\_\_\_  
Payee

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
DDS Service Coordinator

Date: \_\_\_\_\_

\$ \_\_\_\_\_  
Amount Requested

\$ \_\_\_\_\_  
Amount Approved (Initials/Date)