AUTISM SOCIETY
Improving the Lives of All Affected by Autism
Hudson Valley

230 Kings Mall Court #159
Kingston, NY 12401
845-331-2626
Email: hvalleyautism2@gmail.com

2017 Camp Scholarship Application

- Payments to Agency only - **no reimbursement to applicant**
- Application & Documentation must be received by **May 15, 2017**
- **Provide proof of Diagnosis (Doctor's Note or OPWDD Statement)***

Name of applicant:_____

Caregiver's name: _____

Mailing address:_____

Phone number:_____

County of applicant:_____

Camp Program: _____

Contact person: _____

Address: _____

Phone: _____ Email: _____

Dollar amount requested: _____

Has funding for this program been requested from other agencies?_____

_____

You must provide a copy of the unpaid invoice or statement of services and a proof of Diagnosis (Doctor's Note or OPWDD Statement)

Upon receipt of the completed application and required documentation,

Autism Society – Hudson Valley will notify you of your grant status. Please note that if your application is approved, payment will be made directly to the Provider.

Please note that this application will be denied without required documentation*

ASA- Hudson Valley reserves the right to request additional information

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Signature of parent/caregiver: _____

Date: _____

Please mail completed application & required documentation to:

Autism Society - Hudson Valley

230 Kings Mall Court #159

Kingston, NY 12401

THIS SECTION ASA – HUDSON VALLEY, NY USE ONLY:

Date received: _____ Date reviewed: _____

Grant Request: Approved _____ Denied _____

Date Applicant Notified of Grant Status: _____ Notified by: mail/email/phone

Date check mailed: _____Check # _____ Check Amount $_____

Grant Committee Member Signature: _____

Comments:

_____

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