



230 Kings Mall Court #159  
Kingston, NY 12401  
845-331-2626

Email: [hvalleyautism2@gmail.com](mailto:hvalleyautism2@gmail.com)

## 2017 Universal Grant Application

- **Payments directly to provider - no reimbursements\***
  - **HVAS grants are money of last resort**

### Reason for grant:

Resource \_\_\_\_\_ Conference \_\_\_\_\_ Other \_\_\_\_\_  
Professional Continuing Ed\* \_\_\_\_\_ (this is the **ONLY** reimbursable grant)

Name of individual: \_\_\_\_\_  
Address \_\_\_\_\_  
E-mail \_\_\_\_\_ Phone: \_\_\_\_\_  
County of residence \_\_\_\_\_

If not applicant - please state relationship: \_\_\_\_\_

Has applicant been enrolled in OPWDD? \_\_\_\_\_  
Have you requested insurance coverage for this services or item? \_\_\_\_\_

How will this help the individual with ASD or help you in working/caring for individuals with Autism Spectrum Disorder:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider of Service: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Dollar Amount Requested: \$** \_\_\_\_\_

**PLEASE READ** - The Universal Application may be for the person with the Autism Spectrum Disorder, Parent, Professional or Caregiver and can be used for a variety of reasons that are specific to the needs of the individual with ASD.

These grants **WILL NOT** cover daily living expenses or household bills. Please contact your local social service office or other health & human service agencies, some of which may be found on our website. Social skills training, counseling and ABA therapy are now often covered by your insurance, please inquire and obtain documentation of denial or obtain a letter from your provider indicating that they do not accept your insurance plan.

**HVAS funds are limited.** We receive donations from the community fundraisers and we are an all volunteer board. The HVAS grant committee will limit and “cap” our grant amount based on the available finances. *Please support our fund raisers whenever you can!*

**You must supply the following required information:**

- 1. Name of Provider to be paid, address, phone number along with a copy of the UNPAID invoice or statement of services to be provided.**
- 2. Proof of individual’s diagnosis (evaluation, medical statement, etc)**
- 3. Letter of denial of insurance coverage for Social Skills training, Counseling, or ABA therapy if this is the purpose for the grant or letter from provider indicating they do not participate in your insurance plan.**
- 4. ASA- Hudson Valley reserves the right to request additional information**

**Upon receipt of the completed application and required documentation\*, HVAS will notify you of your grant status. Please note that if your application is approved, payment will be made directly to the Provider.**

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

**PLEASE MAIL COMPLETED APPLICATION TO:**

**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 Notified of Grant Status: \_\_\_\_\_ Notified by: mail/email/phone  
Date check mailed: \_\_\_\_\_ Check # \_\_\_\_\_ Check Amount \$ \_\_\_\_\_

Grant Committee Member Signature: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_