



2018 Camp Scholarship Application

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, Hudson Valley Autism Society 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 not be accepted without required documentation.**

***ASA- Hudson Valley reserves the right to request additional information**

42 Crown Street
Kingston, New York 12401
www.hudsonvalleyautismsociety.org



Signature of parent/caregiver: _____

Date: _____

Please mail completed application & required documentation to:

**Hudson Valley Autism Society
42 Crown Street
Kingston, NY 12401**

THIS SECTION ASA – HUDSON VALLEY, NY USE ONLY:

Date received: _____ Date reviewed: _____

Grant Request: Approved _____ Not Approved _____

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

Date check mailed: _____ Check # _____ Check Amount \$ _____

Grant Committee Member Signature: _____

Comments:

**42 Crown Street
Kingston, New York 12401
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