



SCHOLARSHIP APPLICATION 2010

www.giftsretreats.com
 7531 County Route 13, Bath NY, 14810
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Wellness G.I.F.T.S. is pleased to announce that scholarships are available to attend the retreats, through a grant obtained from the Finger Lakes Developmental Disabilities Service Office. To be eligible for the scholarship, the **following criteria must be met:**

Criteria for Application

1. Your child must be living at home with the family and have a developmental disability.
2. Family must reside in Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming or Yates Counties.
3. The following Documentation must be attached:
 - a. Notice of Decision Letter for Wavier Participation OR
 - b. Letter of Enrollment in NYS-CARES OR
 - c. Acceptance letter for OMRDD, Care-at-Home Waivers III, IV, and Vi

If you do not have one of the above, you must obtain an evaluation from your files, teachers, school psychologist, case manager, service coordinator, Doctor's reports or therapists. The evaluation must be done within the last 3 years and be a Standardized Assessment of Adaptive Behaviors (ie. How your child functions in life). The test must include data that shows your child's intelligence scores, motor skills, speech and language skills, social and emotional skills. To be eligible for the scholarship, your child must demonstrate behavior deficits in two of these areas.

ALL SCHOLARSHIP INFORMATION MUST BE MAILED IN BY APRIL 1ST, 2010!

Other organization or sources may be interested in helping you to attend the Wellness G.I.F.T.S. get-a-way retreats? What organizations are you working with?

Agency Name: _____

Amount Received: _____

Do you have a Service Coordinator? Yes No

If Yes: Name: _____

Agency: _____

Address: _____

City: _____ Zip Code: _____

Phone: _____ Email: _____

Each individual applying must use a separate application. Please fill out ALL spaces.

Name of Parent(s)/Caregiver: _____

Address: _____ County: _____

City: _____ State _____ Zip Code: _____

Day Phone: _____ Cell Phone: _____ Email: _____

The following is required information regarding your family member with a developmental disability.

Child's Name: _____ Date of Birth: _____

Social Security Number: _____ Medicaid Number: _____

Is this family member enrolled in the New York State CARES Initiative? ___ Yes ___ No

Nature of Disability (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> 1. Developmental Delay | <input type="checkbox"/> 11. Undetermined |
| <input type="checkbox"/> 2. Mental Retardation | <input type="checkbox"/> 12. Other / Specify |
| <input type="checkbox"/> 3. Autism | <input type="checkbox"/> 13. Traumatic Brain Injury (TBI) |
| <input type="checkbox"/> 4. Cerebral Palsy | <input type="checkbox"/> 14. Prader-Willi Syndrome (PWS) |
| <input type="checkbox"/> 5. Epilepsy/Seizure Disorder | <input type="checkbox"/> 15. Fetal Alcohol Syndrome |
| <input type="checkbox"/> 6. Learning Disability | <input type="checkbox"/> 16. Narcolepsy |
| <input type="checkbox"/> 7. Other Neurological Impairment | <input type="checkbox"/> 17. Neurofibromatosis |
| <input type="checkbox"/> 8. Psychiatric Disability | <input type="checkbox"/> 18. Toxic Substance Exposure |
| <input type="checkbox"/> 9. Chronic Physical Medical Condition | <input type="checkbox"/> 19. Spina Bifida |
| <input type="checkbox"/> 10. Sensory Impairment | <input type="checkbox"/> 20. Tourette Syndrome |
| <input type="checkbox"/> 11. Other _____ | |

Preferred Language:

- English
 Spanish
 None
 Other _____

Non Verbal

- Sign
 Other Symbolic
 None
 Other _____

Understood

- English
 Spanish
 None
 Other _____

Ethnicity/Race:

- | | | |
|--------------------------------|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Hispanic | <input type="checkbox"/> American Indian/Alaskan |
| <input type="checkbox"/> Black | <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Other |

I understand that for the purpose of coordination of services, information may be shared and received with other agencies.

Parent Signature

Date

Please note: Documentation of Developmental Disability (Notice of Decision) is required as part of the application process for each individual with special needs. Remember to enclose it with this application. Final determination of eligibility for scholarship will be determined by the Finger Lakes Developmental Disabilities Services Office.

Please return to: **Wellness G.I.F.T.S. at Hickory Hill**
7531 County Route 13, Bath, NY., 14810 Fax: 607-776-7390

For further information please contact our **Family Registrar: Linda Muller 607-776-0043**