



## SCHOLARSHIP APPLICATION 2011

[www.GiftsRetreats.com](http://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 OPWDD, 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 1<sup>ST</sup>, 2011!**

*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

Does your child with special needs live at your residence? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Nature of Disability** (check all that apply):

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

**Preferred Language:**

- English  
 Spanish  
 None  
 Other \_\_\_\_\_

**Non Verbal**

- Sign  
 Other Symbolic  
 None  
 Other \_\_\_\_\_

**Understands**

- English  
 Spanish  
 None  
 Other \_\_\_\_\_

**Ethnicity/Race:**

- White  Hispanic  American Indian/Alaskan  
 Black  Asian or Pacific Islander  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 for scholarships will be determined by using the Finger Lakes Developmental Disabilities Services Office eligibility criteria.**

Please return by **APRIL 1** to: **Wellness G.I.F.T.S. at Hickory Hill**  
**7531 County Route 13, Bath, NY., 14810 Fax: 607-776-7390**