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

**42 Crown Street**
**Kingston, NY 12401**
**845-331-2626**
**Email: hvalleyautism2@gmail.com**

# 2018 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:

_____
_____

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Provider of Service: _____
Contact Name: _____
Address: _____
Phone: _____ Email: _____

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**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:**

**42 CROWN STREET**

**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: _____
_____