

ADS
PO Box 73
Wappingers Falls, N.Y. 12590
Email: info@adshelps.org

Universal Grant Application

*Checks will be made out to provider and sent to you.

*Provide proof of diagnosis (Doctors note, OPWDD Statement, IEP cover page)

*Applications without sufficient information will not be considered until the packet is complete.

Our goal is to provide grants to those who might not have the means to access assistance to address their special needs.

Please check one: Recreational/Art _____ Educational _____ Social _____
 Conference _____ (this is the only reimbursable grant)

Applicant: Name, address, County, phone and email required

Name of person or organization receiving grant: _____

Program, service or materials for which you are applying:

Name, address, County, phone and email where check should be sent:

Amount requested: \$ _____ (partial payment may be granted)
Has applicant's insurance been billed? Yes _____ No _____ **Include insurance denial**
Check made payable to: _____

Please check off the following to ensure you have included all required information.

- **Completed application**
- **Detailed information about program, invoice for payment directly to provider.**
- **Proof of diagnosis**
- **Current contact including email information of the person applying for the grant.**
- **Please make a copy of your application prior to sending.**

Signature of applicant: _____

All applications are reviewed on a monthly basis.

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Reimbursement only considered with prior board approval.