

<p>The AIDS Foundation of Western Massachusetts, Inc. P.O. Box 30092 Springfield, MA 01103</p>
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REQUEST FOR SUMMER CAMP FUNDING - 2009 - APPLICATION FORM

Name of Child applying for Camp (Last - First -M.I.) _____

Age of Child applying for Camp _____ circle (Female - Male)

Name of Parent/Guardian (Last - First -M.I.) _____

Child's Address _____

City _____ State _____ ZIP _____

Parent/Guardian's Address (if different from Child's address) _____

City _____ State _____ ZIP _____

Phone _____ Social Security Number _____

Case Manager's Name _____ Case Manager's Phone _____

Case Manager's Agency _____

CONSENT TO RELEASE INFORMATION

I, _____ of _____ am applying on behalf of my minor child/ child for whom I am guardian for a grant from the AIDS Foundation of Western Massachusetts, Inc., and I recognize and understand that as part of the grant process, members of the Grant Review Committee and the Board of the AIDS Foundation of Western Massachusetts will have access to information regarding my or my child's or the child for whom I am guardian's HIV status.

I understand that my grant application, which may include information about my HIV status, will be treated in a sensitive manner by the AIDS Foundation of Western Massachusetts, Inc., but cannot be guaranteed by the Foundation, and I hereby expressly authorize the Grant Review Committee and the Board of the AIDS Foundation of Western Massachusetts to discuss my or my child's or the child for whom I am guardian's HIV status as it pertains to the grant review process.

I acknowledge that any assistance given to me by the Foundation is at the sole discretion and option of the Foundation and that dollar assistance levels and criteria for grants are subject to change without notice to me and are further subject to the availability of funds. I affirm that the information submitted in this application is true and submitted in good faith.

Applicant's signature _____ Date _____

The AIDS Foundation of Western Massachusetts, Inc.

Total number of persons in your household: _____

Total number of persons with HIV or AIDS in your household: _____

Ages & relationship to client:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Monthly income for your household: _____

Children 13-18 years old may also join the Boys/Girls club, Dunbar Community center or the YMCA for Summer Youth programs

CAMP INFORMATION

Name of the camp: _____

Address of the camp: _____

Cost of the camp: _____

Contribution from Applicant/ Guardian, if Applicable

Please return this application along with the camp application ready to be mailed to the AIDS Foundation of Western Massachusetts with all the information filled out & money order or bank check for the amount due to the camp over \$400.00 per child.

**The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 30092
Springfield, MA 01103**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Re: **Name of Applicant:** _____

Address _____

Date of birth _____

I understand that I give my express consent to _____ **(name of Physician)** to release Information from my or my minor child or the child for whom I am guardian's medical records relating to my or my minor child or the child for whom I am guardian's HIV status and condition and treatment for HIV (AIDS Virus) to:

**The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 30092
Springfield, MA 01103**

I understand that the specific information to be disclosed is related to my or my minor child or the child for whom I am guardian's HIV status and condition.

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken.

Unless otherwise indicated, this consent will expire in six (6) months.

(Signature of patient parent, legal guardian, personal representative, etc.)

(Date)

Relationship or status if signed by anyone other than patient
(parent, legal guardian, personal representative, etc)

**The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 30092
Springfield, MA 01103**

Name of Applicant: _____
has applied for a grant from the AIDS Foundation of Western Massachusetts, Inc.
To assist the Client we need documentation from you verifying his/her HIV seropositivity
and confirmation that:

Name of Applicant: _____,
would be classified as having AIDS.

Please complete this form and return it as soon as possible.

Date tested HIV positive _____

CD4 count _____ Date _____

AIDS defining illness _____

Print Physician's name

Physician's signature

Date

Attached is an authorization to release medical information authorizing you to share this
information with the AIDS Foundation of Western Massachusetts, Inc. Please return this
form to us and retain the authorization for your records.

Thank you for your assistance.

Sincerely,

**The Grant Review Committee,
The AIDS Foundation of Western Massachusetts, Inc.**

The AIDS Foundation of Western Massachusetts, Inc.

P.O. Box 30092
Springfield, MA 01103

INFORMATION ABOUT THIS REQUEST FOR SUMMER CAMP FUNDING

- The AIDS Foundation of Western Massachusetts, Inc. (The Foundation) is a non-profit public foundation that provides grants to people and their families and/or significant others who have been diagnosed with HIV and AIDS.
- Financial assistance for camp funding will be a one-time additional grant for the year 2009 only, and will be available on a first come-first served basis.
- The maximum award granted for each child will be \$400.00.
- These awards will not affect the Client or the Client's family in their eligibility for future grants requests from the AIDS Foundation, and will not be included in a Client's lifetime eligibility of up to \$750.00 in a six month period or \$2,000.00 in his or her lifetime. If a Client has already received his or her maximum grant, they are still eligible to receive camp funding.
- Grants for camp financial assistance are subject to availability of funding.
- Applicants for camp financial assistance must be 18 years of age or younger.
- A parent or parents infected with HIV/AIDS are eligible to apply for camp financial assistance for their uninfected child or children, but priority will be given to children infected with the AIDS virus and diagnosed with HIV or AIDS.
- Recipients of camp funding grants must be residents or homeless in Hampden or Hampshire counties.
- The camps to which applicants wish to attend must be registered, certified and accredited in the state of Massachusetts.
- All approved grants will be paid by check to the provider of camp services. For reasons of confidentiality, the name of the Foundation does not appear on the check.
- **Send application ready to be mailed with total amount due over \$400.00 per child in the form of a money order.**