The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 86
Chicopee, MA 01014

REQUEST FOR SUMMER CAMP FUNDING - 2017 - APPLICATION FORM

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

Age of Child applying for Camp_____

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 emergency funds process, members of the Emergency Financial Assistance Review Committee and the Board of The AIDS Foundation of Western Massachusetts will have access to information regarding my or my child or the child for whom I am guardian's HIV status.

I understand that my financial assistance 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 Emergency Financial Assistance 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 financial assistance 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: _____

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 $600.00 per child, or proof that this amount will be otherwise covered.

The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 86
Chicopee, MA 01014

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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 86
Chicopee, MA 01014

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)

Case Number _____ Document # 1

The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 86
Chicopee, MA 01014

Name of Applicant:_____
has applied for financial assistance 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 Emergency Financial Assistance Review Committee,
The AIDS Foundation of Western Massachusetts, Inc.

The AIDS Foundation of Western Massachusetts, Inc.
P.O. Box 86
Chicopee, MA 01014

INFORMATION ABOUT THIS REQUEST FOR SUMMER CAMP FUNDING

- The AIDS Foundation of Western Massachusetts, Inc. (AFWM) is a non-profit public foundation that provides financial assistance 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 application for the year 2017 only, and will be available on a first come-first served basis.

- The maximum award granted for each child will be $600.00.

- Campership financial assistance is 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 diagnosed with HIV or AIDS.

- Recipients of camp funding must be residents/homeless or receiving treatment for HIV or AIDS in Hampden or Hampshire counties.

- All approved financial assistance 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.

- The camps to which applicants wish to attend must be registered, certified and accredited.

- **Send application ready to be mailed with total amount due over $600.00 per child in the form of a money order, or proof that the amount over $600.00 will be otherwise covered.**