



Spina Bifida Association  
of Connecticut

Please Print

Today's Date: \_\_\_\_\_

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**Application for CAMPERSHIP Assistance**

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Name of person for whom aid is being requested: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail \_\_\_\_\_

Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Night Phone: (\_\_\_\_\_) \_\_\_\_\_

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Camp Name: \_\_\_\_\_  Day Camp  Overnight Camp

Address: \_\_\_\_\_ State: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Total Tuition: \$ \_\_\_\_\_ Other Financial Aid: \_\_\_\_\_ \$ \_\_\_\_\_

Dates of Attendance: \_\_\_\_\_

**Attach a copy of the camp brochure and invoice showing total tuition.**

All of the information contained on this form is true and correct to the best of my knowledge. I hereby give the SBAC permission to verify any of this information. I understand that distributions will only be awarded according to the SBAC Campership policy.

Signed, \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Rules for Application**

1. Applicant must have spina bifida. A physician statement of disability is required, including the physician's address and phone number.
  2. Applicant must reside within the SBAC service area, the State of Connecticut.
  3. We reimburse out of pocket expenses only. We will NOT duplicate any expense already paid for by an insurance company or state, federal or private agencies.
  4. All applications must be accompanied by all requested documentation.
  5. CAMPERSHIP applications must be **postmarked** by **September 1<sup>st</sup>**.
  6. Checks will be made payable to the Camp or facility, unless a paid invoice is provided.
  7. All expenditures must have been incurred within 12 months of the application deadline.
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