

FLORIDA DIABETES CAMP APPLICATION FOR FINANCIAL AID

This form must be completed (both pages) and signed in order to receive financial assistance to attend a program offered by Florida Diabetes Camp (FCCYD). This policy applies to families applying for full or partial assistance and to families seen through the CMS network. The policy of Florida Diabetes Camp is to ensure that all eligible children can attend the programs regardless of how much the family can contribute to the costs of the program. All applications to programs must be accompanied by a minimum \$ 25 deposit which is applied to the cost of the program. Financial aid applicants are notified of award in advance of the program by phone or regular mail.

Date submitted to camp office: _____ Program applying for: _____

CAMPER'S FULL NAME: _____ Date of Birth _____

ADDRESS: _____

Name of Parent or Guardian _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name & relationship of person completing this form: _____

Total cost of program to which you are applying: _____

Amount that family can contribute (after \$25 deposit) _____ (payment plans available)

THE FOLLOWING INFORMATION MUST BE COMPLETED IN FULL:

Florida Diabetes Camp is not associated with any national diabetes organization and has limited scholarship resources. Therefore to ensure coverage for all in need, we must take into account the income of all individuals living in the household including step-parents.

- | | |
|-----------------------------|-----------|
| 1. Place of Employment: | Position: |
| Mother _____ | _____ |
| Father _____ | _____ |
| Step-parent _____ | _____ |
| Step-parent _____ | _____ |
| Foster parent _____ | _____ |
| Custodial Grandparent _____ | _____ |

2. Number of People Living in Household in which camper resides:

NAME	RELATIONSHIP	AGE

3. MONTHLY Family Income – TOTAL for ALL living in the household:

1. Salaries and Wages \$ _____

(TURN OVER)

2. Other sources of income
(Disability, social security,
retirement, unemployment) \$ _____

3. Child Support \$ _____

**TOTAL GROSS MONTHLY FAMILY
INCOME: \$ _____**

4. Please note any unusual or special financial circumstances that may require consideration:

5. ALL applicants please answer the following questions:

1. Is camper in foster care? YES NO
 2. Is household eligible for food stamps? YES NO If yes, number _____
 3. Is camper eligible for reduced school lunch? YES NO
 4. Is camper eligible for free school lunch? YES NO
 5. Is camper eligible for Medicaid? YES NO Medicaid number (required) _____
 6. Is camper seen by Children's Medical Services for health/medical care? YES NO
- REQUIRED: CMS Network Number _____
- CMS Care Coordinator Name: _____
- Care Coordinator Phone number with area code & extension: (____) _____
- Please submit a copy of your Medicaid and/or CMS Network card with this application*

We encourage families and campers to seek their own sponsorships through local service organizations such as Kiwanis, Rotary, Lions, Eagles, Veterans or other clubs. Grants are also often available through employers and churches. You can contact our office at 352-334-1323 to request a packet on how to find a sponsorship. Any amount raised by the family in this way, may be matched by our scholarship fund.

If you have secured a sponsorship from another source already please indicate:

SPONSOR NAME (Club, Individual, Business etc.) _____

Contact Person if applicable: _____ They have pledged: \$ _____

Sponsor Address: _____ City: _____ State _____ Zip _____

Sponsor check should be made out to Florida Diabetes Camp and indicate the camper's name in bottom left corner and mailed to address below

By applying for financial assistance I give permission for FCCYD, Inc. to use our name and our child's name when seeking scholarship assistance specifically for our family. Further I certify that the statements and information made in this application are true and correct.

Legal Guardian/Parent must sign _____ **(date)** _____

MAIL THIS FINANCIAL AID APPLICATION WITH THE PROGRAM REGISTRATION BY THE DEADLINE POSTED ON THE PROGRAM REGISTRATION FORM. DO NOT WAIT FOR SCHOLARSHIP NOTIFICATION BEFORE SENDING PROGRAM REGISTRATION. ALL APPLICATIONS MUST BE ACCOMPANIED BY \$ 25.00 DEPOSIT.

**SEND TO:
FLORIDA DIABETES CAMP
PO BOX 14136
GAINESVILLE, FL 32604**