# N:\My Pictures\Frank Bucino Jr..jpegFrank Bucino Jr. Memorial Scholarship

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## Identifying Information:

Applicant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Qualifying Individual: Date of Birth

Address

Phone Email

Please provide the names of immediate family/caregivers who will be attending the event with the applicant above and seek assistance from the scholarship (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Event Information:**

Event date & location:

Event attendance will require (check all that apply):

⬜ Travel by

⬜ Lodging for \_\_\_\_ nights ⬜ Registration Fees $

Programs that you have participated in related to Spina Bifida and/or your disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have these programs been helpful? Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Attachments:**

1. A short essay (from three to five paragraphs) in the applicant’s own words the reasons for wanting to attend, goals for attending, and how the event will help empower and improve the quality of life of the applicant.
2. If you have not signed up for SBANYS programs and services prior to applying, provide a doctor’s note, on letterhead, confirming a diagnosis of Spina Bifida.

All materials related to the application should be sent to and will remain the property of:

Spina Bifida Association of New York State

133 Saratoga Road, Pro Bldg, Office 4

Scotia, NY 12302

I hereby affirm that this application contains no willful misrepresentations or falsifications and that this information given by me is true and complete to the best of my knowledge and belief. I am aware that should investigation at any time disclose any misrepresentation or falsification, my application will be disapproved, and my award may be rescinded.

Date

Applicant Signature (Parent/Guardian signature required if qualifying individual is a minor child.)

Applicants with questions may call (518) 399-9151 or email [admin@sbanys.org](mailto:admin@sbanys.org)