SPINA BIFIDA ASSOCIATION OF NEW YORK STATE

Frank Bucino Jr. Memorial Scholarship

Sponsored by

Spina Bifida Association of New York State
133 Saratoga Rd, Pro Bldg, Office 4
Scotia, NY 12302 (518) 399-9151
admin@sbanys.org

Spina Bifida Association of New York State (SBANYS) has established the Frank Bucino, Jr. Memorial Scholarship in cooperation with Frank's family. The purpose of the scholarship is to award financial assistance to support individuals who have Spina Bifida and their immediate family's attendance at a national or regional Spina Bifida related education event. The scholarship award is intended to be used toward costs related to event attendance including registration fees, transportation, and/or lodging.

Eligibility Requirements:

1. Applicants must have Spina Bifida or be the parent/caregiver of an individual living with Spina Bifida AND must reside in the geographic area serviced by SBANYS. Immediate family/caregivers may also benefit from the award for the purpose of assisting them to attend the event.
2. There is no age limit.
3. Applicants must demonstrate a desire and plan to attend an upcoming education event related to Spina Bifida.
4. No financial statement shall be required.

Selection Process:

1. Applicants must apply for this award.
2. Applications will be accepted at any time during the year. There is an expectation for award recipients to be decided upon within six weeks thereafter.
3. An application will consist of:
    a. A completed application form.
    b. 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.
    c. Event to be attended must be specified. If reapplying, the essay should be updated to be current.
    d. 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.
4. A virtual interview with the Scholarship Committee.
5. Selection of the recipient(s) shall be made by a majority vote of the Scholarship Committee. Recipient(s) will be notified within 3 months from when they apply.
6. Additional information may be requested depending upon the nature of the applications received.

SPINA BIFIDA ASSOCIATION OF NEW YORK STATE

Selection Criteria:

1. The exact amount to be disbursed will be at the discretion of the Scholarship Committee.
2. The number of scholarship applicants will be a factor in this decision.
3. The ability of the association to award scholarships for subsequent years to the same applicant will be dependent upon the number of applications received each year and will be at the discretion of the committee. All applicants must reapply.

Award:

1. Actual payment shall be made by check payable to the recipient(s) upon receipt of proof of eligible expenses.

Scholarship Committee

The committee shall comprise:

1. The SBANYS Board Chair or a designee.
2. Two additional members of the association.
3. One member shall be designated as chairperson.
4. Relatives of an applicant shall recuse themselves from that particular discussion and vote.

SPINA BIFIDA ASSOCIATION OF NEW YORK STATE

APPLICATION

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):

_____

_____

Event Information:

Event name, 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:

_____

_____

_____

SPINA BIFIDA ASSOCIATION OF NEW YORK STATE

Have these programs been helpful? Why or why not?

_____

_____

_____

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 the investigation at any time disclose any misrepresentation or falsification, my application will be disapproved, and my award may be rescinded.

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

_____

Date _____

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