



Summer Scholarship Request

Awarded on a first come, first serve basis

Family Information

Child's name: _____ Child's Age: _____

Parent's name: _____

Street Address: _____ City/State/Zip: _____

Phone Number: _____

Experience Information

Camp/Company to provide the service: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____ Fax: _____

Total cost \$ _____

Statement of Understanding

The summer scholarship requires that families check alternative sources before requesting summer scholarship funds. Before making a request, please check to see if other sources are available (e.g., private insurance, Medicaid, Medicare, church, Lions Club, Kiwanis, other agencies).

Are other funding sources available to pay for any portion of this service?

Yes No

Payment

Where should payment be issued? Family Reimbursement Camp Listed Above

Pay to the order of: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Acknowledgement

I acknowledge and agree that selection of providers for the requested services is my responsibility. Neither the Fairfield County Board of Developmental Disabilities nor any of its staff, management or administration assumes or implies any liability for service providers' actions or the quality of care provided. All requests must be submitted to familysupport@fairfielddd.com on or before 07/31/2026.

Parent Signature

Date