Employee & Family Discount Application

Contact Information

Name	
Business Name	
Street Address	
City, ST, Zip Code	
Home Phone	
Work Phone	
E-Mail Address	
Hours of Operation	

What discount/benefit are you offering employees & ACA families?

Discount/benefit	
Limits	

Terms

- This agreement is in effect for a 12 month period:
  Start date: _____ End date: _____
- I understand that Anderson Center for Autism employees or family member must show their ACA ID badge and corresponding coupon. Contact ACA's HR Director at 845.889.9216 with any concerns.
- I agree to collect ACA coupons during this period allowing ACA to track usage.
- I understand that transactions are solely between the customer and the business proprietor; Anderson Center for Autism bears no responsibility.
- I agree that either party may cancel this agreement without cause. However, a letter of notification will be sent to the other party 1 week prior to termination. *Cancellation from the program does not prevent individuals from attempting to receive discounts.*

Agreement and Signature

By submitting this application, I affirm that I agree with the terms set forth above.

Name (printed)	
Signature	
Date	