



233 Fulton St E | Ste 124
 Grand Rapids, MI 49503
 Telephone 616.956.3488
 Fax 616.272.4484

Member Adoption Assistance Application Form **Date:** _____

The Down Syndrome Association of West Michigan has established an Adoption Assistance Fund to help DSAWM members who are planning to adopt an individual with Down syndrome. Payment will be made directly to the adoptive parent(s) at the conclusion of the adoption process.

Assistance requests of up to \$1,500.00 may be approved for Members in Good Standing (see below). Prior to approval of your application, membership and volunteer requirements must be met. Please contact the DSAWM Administrative Assistant at 616-956-3488 with questions regarding these requirements.

To Qualify for Funding, an Applicant Must Meet the Following Requirements:

- Live in the West Michigan service area as defined by the Board of Directors
- Be a current year voting member
- Provide a minimum of two (2) hours of volunteer service in the year assistance is requested

Please complete and mail this form to the address in the top right corner of this form. A copy of the provider (attorney) invoice or statement must be included. Thank you!

Name & Age of Individual with DS _____
 Parent/Guardian Name(s) _____
 Street Address _____
 City/State/ ZIP _____
 Phone Number _____ E-mail Address _____
 Adoption Agency (Name, Contact Person, E-mail Address & Phone Number) _____

Source(s) of Funding (including insurance) _____
 Family Cost (After Funding Source(s)) \$ _____ Amount of Assistance Requested \$ _____

As a Member in Good Standing, I Am Involved with the DSAWM in At Least Two (2) of the Following:

_____ Attend Workshops/Conferences	_____ Attend School-Age Programs
_____ Attend Step Up for Down Syndrome	_____ Attend Young Adult/Adult Programs
_____ Attend Member Gatherings	_____ Attend Playgroups or Parent Coffee
_____ Attend Early Stage Programs	_____ DSAWMF or Financial Contribution

I Have Volunteered for a Minimum of Two (2) Hours in the Following Areas:

_____ Event/Activity Volunteer	_____ Office Support
_____ Board/Committee Member	_____ Parents for Parents Veteran Parent
_____ Translator	_____ Other _____

Your request will be considered, and reimbursement will be made upon approval by DSAWM staff.

By signing, you acknowledge that the above is correct to the best of your knowledge Date _____

DSAWM Office Use Only		
_____ Membership Current	_____ West Michigan Resident	_____ Member in Good Standing
_____ Volunteer Hours Met	_____ Provider Invoice Included	_____ Proof of Payment Included
_____ Amount Approved	_____ Approval Signature and Date	