DSAWM
Down Syndrome Association of West Michigan
Empowering individuals. Supporting communities.

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

Member Financial Assistance Application Form

Date: _____

The Down Syndrome Association of West Michigan has established a Financial Assistance Fund to help DSAWM members meet financial obligations, in the areas of education, recreation, medical and therapeutic services, for their children with Down syndrome. Payment will be made in the form of reimbursement to the member after proof of payment has been shown.

Partial reimbursement of 80% of total costs, not to exceed an annual amount of $500 per child with Down syndrome, may be approved for Members in Good Standing (see below). Reimbursement is available for financial obligations to be met in the current year ONLY.

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 *Member in Good Standing* for a minimum of two (2) years
- Be a current year voting member
- Provide a minimum of two (2) hours of volunteer service in the year assistance is requested

Funding is available on a first-come, first-serve basis. Priority is given to applicants who have not applied or received funding in the current year. Once funds have been exhausted, no additional funding will be available in the current year.

Please Note: Pre-payment of funds is prohibited. If a program is not financially possible without first receiving assistance, payment will be made directly to the service provider.

Applicants May Request Funding for the Following Programs and/or Services:

- **Education & Recreation Programs (Tutoring, Camp, Athletics, etc.)**
  - Information on services and/or activities must be submitted with the Member Financial Assistance Application Form, including an explanation as to how the proposed funding will benefit the applicant with Down syndrome.
- **Medical & Therapeutic Services (Therapies, Equipment, Treatment, etc.)**
  - Information on services must be submitted with the Member Financial Assistance Application Form, including an explanation as to how the proposed funding will benefit the applicant with Down syndrome. Funding is not available for the payment of insurance premiums.

Questions regarding Member Financial Assistance Fund eligibility requirements or qualifying services may be directed to the DSAWM Administrative Assistance at 616-956-3488.

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

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Member Financial Assistance Application Form Date: _____

Applicant Information

Name & Age of Individual with DS _____

Parent/Guardian Name(s) _____

Street Address _____

City/State/ ZIP _____

Phone Number _____ E-mail Address _____

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

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

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

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

Program/Service Information

Name & Location _____

Description _____

_____

_____

Length & Frequency (daily, weekly, etc.) _____

Expected Outcome for Individual with DS _____

_____

Total Cost of Program/Service $_____ Other Funding Source(s) _____

Will Your Child Be Able to Participate Without Member Financial Assistance Funds?

Please Check One: ☐ NO ☐ YES, with financial difficulty ☐ YES

Thank you! 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
___ Volunteer Hours Met
___ West Michigan Resident
___ Provider Invoice Included
___ Member in Good Standing
___ Proof of Payment Included

_____ Amount Approved

_____ Approval Signature and Date