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

160 68th St. SW, Ste. 110
Grand Rapids, MI 49548
Telephone: 616-956-3488

Member Financial Assistance Application Form

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 our office 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-served 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 ______________________________

Street Address ______________________________

City ______________________ State ____________ Zip ____________

Phone Number ____________________ Email ____________________

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 Stages Programming
- ☐ Attend School-Age Programs
- ☐ Attend Teen/Adult Programs
- ☐ Attend Parent Gatherings
- ☐ DSAWMF or Financial Contribution

I have volunteered for a minimum of two (2) hours in the following areas:

- ☐ Event/Program Volunteer
- ☐ Board/Committee Member
- ☐ Translator
- ☐ Office Support
- ☐ Parents for Parents Mentor
- ☐ Other ____________________

Program/Service Information

Name & Location ______________________________

Description ______________________________

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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 support?

☐ No ☐ Yes, with financial difficulty ☐ Yes

______________________________ ______________

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

Thank you! Your request will be considered, and reimbursement will be made upon approval by DSAWM.

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 & Date