Member Financial Assistance Application

Please read the Financial Assistance Guidelines thoroughly before completing this application.

- Every question must be answered for the application to be complete.
- Applications are accepted any time but are only reviewed in the months of January, May, and September. Decisions are sent to applicants no later than the final day of the review month. Applications received after the first (1st) of January, May, or September will be held until the next scholarship period.
- If applying for multiple invoices from different services, please submit separate applications for each program. (i.e. if you are applying for money to reimburse a doctor's visit copay and money toward tutoring, this would require two separate applications)
- If applying for adoption assistance, please use the Adoption Assistance Application.

The Down Syndrome Association of West Michigan has established a Member Financial Assistance Fund to help DSAWM members meet financial obligations for their children with Down syndrome. Scholarships are available for the following categories:

- **Medical and therapeutic services** such as doctor appointments, surgeries, medical procedures, speech therapy, occupational therapy
- **Equipment or devices** such as gait trainers, orthotic devices, AAC devices, glasses, hearing aids
- **Programs** such as therapeutic or educational services, tutoring, hippotherapy, etc.

Payment will be made in the form of reimbursement to the member after proof of payment has been shown. In some cases, DSAWM may pay a medical or therapy provider directly with proof of a current invoice. Reimbursement amount is at the discretion of the DSAWM Financial Assistance Committee and will not exceed $500 per member per calendar year. Preference will be given to members who have not previously received financial assistance. Reimbursement is available for financial obligations to be met in the current year ONLY. 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 DSAWM service area
- Be a current year voting member

Applications will be reviewed tri-annually and ranked in order of highest need. Preference will be given to services & equipment prescribed by a medical provider. Should additional funds be available, the committee will consider applications for elective programs such as camps.

Please complete all information and submit a scanned copy, including additional documents, to info@dsawm.org or mail to the address below:

DSAWM
Attn: Financial Assistance Committee
160 68th St. SW
Suite 110
Grand Rapids, MI 49545

Down Syndrome Association of West Michigan
160 68th St. SW, Ste. 110, Grand Rapids, MI 49548
616-956-3488 | www.dsawm.org

Applicant Information

Member's Name: _____ Date: _____
Last First M.I.

Parent/ Guardian: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State ZIP Code

Phone: _____ Email: _____

County: _____

General Information

Has applicant applied for a DSAWM scholarship in the past? YES ☐ NO ☐

If yes, has applicant received a DSAWM scholarship in the past? YES ☐ NO ☐

Are you a current dues paying DSAWM member? YES ☐ NO ☐

Financial Aid Request

Amount of scholarship being requested: $_____(Not to exceed $500)

Organization providing the equipment, treatment, or program: _____

Which of the following best describes your request? (Check only one)

☐ Medical Service ☐ Therapy ☐ Device/Equipment ☐ Elective Program

Detailed description of request (i.e. What is the program/service? Why does your child need this service? What is the financial impact to your family?). Attach additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

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Empowering individuals. Supporting communities.

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How does this expense specifically support your child with their Down syndrome diagnosis (i.e. “Due to low tone, my child has a speech delay. In speech therapy he is working on forming the ‘s’ and ‘ch’ sounds.” or “Camp Roger provides additional staff for children with cognitive impairments and behavioral challenges.”)

Total cost of treatment/equipment/program: $ _____

Will insurance cover any portion of the costs associated with this request? YES ☐ NO ☐

What medical coverage does the applicant have? (Check all that apply)

☐ Private Insurance ☐ Medicaid/MI Child ☐ Children’s Special Healthcare ☐ None

Additional Information

A minimum of one of the following is required. Please mark which type of document(s) you are attaching:

☐ Doctor’s note, prescription, or statement of need from provider

☐ Invoice for service/equipment/program

☐ Proof of payment to provider

Please explain how this scholarship would benefit the applicant and your family. Attach an additional page if needed.

Agreement & Signature

This application was completed by (print): _____

Relationship to applicant (member): _____

I certify that my answers are true and complete to the best of my knowledge. If a scholarship is awarded, I agree to use the funds for the need specified in the application. Additionally, within 1 year of receiving funds, I will provide a statement of impact to DSAWM expressing how the funds impacted the applicant.

Signature: _____ Date: _____

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