MONTANA DOWN SYNDROME ASSOCIATION
Financial Assistance Application

Eligibility: The person benefiting from the financial assistance must have Down syndrome and must be a resident of Montana. Please provide verification of diagnosis.

All expenses must be documented and not covered by insurance or any other funding source. Insurance premiums are not eligible.

Expenses eligible for financial assistance must have been accrued in the past 6 months or must be for future expenses that are documented by source and amount of the expense.

Areas Eligible for Assistance:

- Therapeutic services and associated adaptive and specialized equipment expenses.
- Medical expenses, including associated travel expenses.
- Educational/recreational expenses for programs that enhance and enrich personal development.

Applications should be submitted in a timely manner to give board members enough time to meet and consider applications. Board members meet monthly.

Please fill in all of the information requested and please include receipts or any documentation from the provider for all expenses for which you are applying for funding.

Date of application:_____

Applicant Name: _____ Date of Birth_____

Parent or Legal Guardian:_____

Address:_____

City_____ State:_____ ZIP:_____

Phones: Cell_____ Home_____ Work_____

Please describe the services/equipment or travel expenses for which you are applying for assistance and/or the intended use: _____

_____

_____

_____

Please describe how the applicant will benefit from this service/program or equipment:

_____

_____

_____

_____

Please describe need for financial assistance:

_____

_____

_____

If applicable, please fill in the Service or Program Information:

Service/Program_____Organization_____

Service/Program Dates_____ Service/Program Cost_____

Service/Program Contact Person _____Phone number_____

Amount Requested: _____

CERTIFICATION AND RELEASE OF INFORMATION:

I certify that all of the above information is true and correct to the best of my knowledge. I understand that false or misleading information may be grounds for rejection of my application.

I understand that this application does not guarantee financial assistance from the Montana Down Syndrome Association. I understand that if I am awarded monetary assistance that all money may be sent directly to the organization providing the services and that it will not be available to me for refund or reimbursement.

I release the Montana Down Syndrome Association from any harm or negative consequences that may result from activities for which the monetary assistance was provided. I understand that the Montana Down Syndrome Association has no control over or direct involvement with the organizations that may be providing services and programs.

SIGN BELOW TO INDICATE THAT YOU HAVE READ AND AGREE TO THE ABOVE:

_____ _____

PARTICIPANT **PARENT/LEGAL GUARDIAN**

_____ _____

DATE **DATE**

___ Awarded _____ Amount ____Declined Reason_____