Grant Application

The DSAL grant program is intended to provide financial assistance for products & services that directly improves the quality of life of individuals with Down syndrome. The program will consider applications to cover the cost of services including, but not limited to, recreational programs such as camp, educational programs & tutoring, all therapies not covered by insurance, medical expenses not covered by insurance.

PLEASE READ THE GRANT APPLICATION GUIDELINES BEFORE SUBMITTING THIS APPLICATION

Family & Applicant Information

1.Name of Caregiver / Parent / Guardian 1: _____

Address _____

City_____ State_____ Zip_____ County _____

Cell Phone_____Email_____

2. Name of Caregiver / Parent / Guardian 2: (if address is different please add additional pages)

_____

Cell Phone_____Email_____

3. Do you have other family or persons you are responsible for that have special needs? ( ) Yes ( ) No

3.a. If yes, please list who (i.e. sibling, parent, etc) and diagnosis, disability, etc.

4. Child / Individual's Name Receiving Product or Service_____

5. Nickname_____Date of Birth_____ Male / Female (gender at birth, circle one)

6. List secondary and all other diagnosis / disabilities associated with individual applying for grant funds (attach additional pages if needed)

_____

7.Has this applicant applied for a Dsal Grant in the past? ( ) Yes ( ) No

8.If yes, has this applicant received a Dsal Grant in the past? ( ) Yes ( ) No

9. Applicant's Medical Coverage (Check all that apply)

( ) Private Insurance ( ) Medicaid ( ) Other ( ) None

10. Does/Would Insurance cover any of the costs associated with this grant request? ( ) Yes ( ) No ( ) n/a

11. Check which best describes your employment:

( ) Employed ( ) Unemployed ( ) Student ( ) Retired ( ) Disability Income

12. Check which best describes your household income (may not be used for determination):

( ) $19,000 or less ( ) $20,000 and $59,000 ( ) $60,000 and $99,000 ( ) $100,000 or above

13. Explain any circumstances that contribute to your financial need (attach additional pages if needed):

14. Will the product / services being requested be purchased out of pocket if the grant is not awarded? If yes, how will this affect the overall financial health of the household? (Attach additional pages if needed):

15. May we share your story? ( ) Yes. ( ) No

16. What are the biggest stress factors for your household right now?

17. Are there programs, activities, groups and information you'd like to learn more about or see DSAL provide?

Activity/Therapy/Product Information

Activity / Camp

18. Activity / camp Name, Contact Name, address, phone #, email:

19. Activity / Camp Dates:_____ Tuition:_____ Amount Requested:_____

Therapy / Tutoring / Counseling

20. Cost per session _____ # of sessions _____

21. Each session lasts how long in minutes?_____ Total dollar amount requested:_____

22. Therapy / tutoring / counseling Name, Contact Name, address, phone #, email:

23. Has the applicant received therapy from this provider in the past? ( ) Yes ( ) No

24. If not, has the applicant already been evaluated by this provider? ( ) Yes ( ) No

25. Who is the service being requested by? ( ) Physician ( ) 3rd party therapist ( ) Other _____

Physician/Therapist/Other: Name, Practice name & address:

Product Information

26. Who is this product being requested by? (List above) ( ) Physician ( ) 3rd party therapist ( ) Other _____

27.Product/s requested _____ Cost _____

Product/s requested _____ Cost _____

28. Will this/these items be used at home or school? Please indicate for each.

Supporting Documents

REQUIRED:

29. Include a letter from the applicant's Doctor confirming the applicant's diagnosis. The letter must be on company letterhead and signed by the MD him/herself. *If you have submitted this in the past there is no need to resubmit a diagnosis letter.

30.Please attach any/all information to support this request, including brochures, pictures, statements from Physicians, therapists, other professionals, experts in the field, etc.

31.Explain why this Activity/Therapy/Product will be beneficial to the applicant. What are the expected results, what will you see from this product / treatment? (attach additional sheets if needed):

Submit the completed and signed application with all supporting documents to dsalgrants@gmail.com

*If the applicant is selected to receive a grant, I commit to providing all follow-up requirements and paperwork specific to the applicants request within fourteen (14) days of the date of request.

_____ _____

(Signature) (Date)

Please note, we cannot reimburse or pay for programs for applicant's participation in prior or future years. This is intended for current programs only.

For PAYMENT (include invoice or purchasing information). *Include URL if item requested will be purchased from the internet. For ongoing therapies, DSAL will work with your provider directly.

WEBSITE, SOCIAL MEDIA, AND PRINTED MEDIA RELEASE FORM

I, the undersigned, do hereby grant permission to the Down syndrome Association of the Lowcountry to post my and/or my child story, photos, or other items, hereinafter referred to as "materials", I submit to the Down syndrome Association of the Lowcountry's website as well as their social media accounts which include Facebook, and Instagram, as well as printed media.

I hereby release you, your representative, employees, managers, members, officers, parent companies, subsidiaries, and directors from all claims and demands arising out of or in connection with any use of said "materials", including, without limitation, all claims for invasion of privacy, infringement of my right of publicity, defamation and any other personal and/or property rights.

I acknowledge and agree that no sums whatsoever will be due to me because of the use of the "materials" or any rights therein.

_____ _____

Signature of Recipient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Recipient

_____

Name of Grant Recipient

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECIPIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Therapy/Tutor/Counselor Provider

I, the undersigned, do hereby authorize and request the disclosure of protected information for the sole purpose of review and evaluation in connection with the issuance of the Down syndrome Association of the Lowcountry grant.

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My grant cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the information requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

_____ _____

Signature of Recipient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Recipient

_____

Name of Grant Recipient