dsaa
Down Syndrome Association of Acadiana
Together... families dream, hope, and soar

STIPEND APPLICATION FORM

DATE OF APPLICATION _____

APPLICANT'S NAME _____

APPLICANT'S AGE _____

NAME OF PARENT/LEGAL GUARDIAN (if applicable) _____

ADDRESS, CITY, STATE, ZIP CODE _____

PHONE NUMBERS Daytime Phone _____

Evening Phone _____

EMAIL ADDRESS (if applicable) _____

IS YOUR DSAA MEMBERSHIP CURRENT? ☐ Yes ☐ No ☐ Don't Know

CATEGORY OF FUNDING REQUESTED (select one)

☐ Education

☐ Medical

☐ Recreation

SPECIFIC ITEMS OR SERVICES REQUESTED _____

ESTIMATED COST/AMOUNT OF ITEMS/SERVICES REQUESTED $ _____

(REMINDER: DSAA DOES NOT PAY APPLICANTS DIRECTLY. IF THE STIPEND APPLICATION IS APPROVED, DSAA WILL REIMBURSE THE APPLICANT ONCE PROOF OF PAYMENT IS SUBMITTED. PROOF OF PAYMENT MAY BE SUBMITTED WITH THIS FORM.)

BRIEFLY EXPLAIN HOW YOUR REQUEST WILL BENEFIT YOUR FAMILY MEMBER WITH DOWN SYNDROME. _____

DATE BY WHICH FUNDS ARE NEEDED _____

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HAVE YOU EXPLORED OTHER RESOURCES FOR SECURING FUNDS?

☐ Yes ☐ No

If Yes, please list these resources:

_____

HAVE YOU APPLIED FOR A DSAA STIPEND SINCE JANUARY 1ST OF THIS YEAR?

☐ Yes ☐ No

If Yes, please enter the month the previous request was made:

_____

THIS SECTION IS FOR MEDICAL SERVICES ONLY.

IS THERE INSURANCE AVAILABLE TO APPLICANT? ☐ Yes ☐ No

If Yes:

_____

What type of insurance is available to the applicant (i.e., HMO, PPO, Medicaid)? _____

What is the out-of-pocket expense per visit or procedure? $ _____

UPON APPROVAL, PLEASE MAKE PAYMENT TO:

NAME _____

ADDRESS, CITY, STATE, ZIP CODE _____

SIGNATURE _____

SIGNATURE _____

Please complete, print, sign, and mail this form
to: DSAA Stipend Committee
P.O. Box 81323
Lafayette, Louisiana 70598-1323

Or by email to: dsaa@dsaa.info