

**COLORADO SPRINGS DOWN SYNDROME ASSOCIATION
SCHOLARSHIP FUND APPLICATION**

DATE SUBMITTED: _____

APPLICANT'S NAME: _____ AGE: _____

PARENT OR LEGAL GUARDIAN OF APPLICANT (IF APPLICABLE) _____

ADDRESS: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

E-MAIL ADDRESS: _____ (IF AVAILABLE)

CSDSA MEMBERSHIP CURRENT? YES or NO (CIRCLE ONE)

CATEGORY OF FUNDING BEING REQUESTED: _____
(EDUCATION, MEDICAL SERVICES OR RECREATION)

ITEMS/SERVICES REQUESTED BY APPLICANT: _____

ESTIMATED AMOUNT/COST FOR ITEMS/SERVICES REQUESTED: \$ _____
(REMINDER: CSDSA DOES NOT PAY THE APPLICANT DIRECTLY BUT IF APPROVED WILL EITHER
REIMBURSE THE APPLICANT OR WILL FORWARD ANY APPROVED FUNDS DIRECTLY TO THE PROVIDER)

PLEASE PROVIDE BRIEF DETAILS ON HOW YOUR REQUEST WILL BENEFIT YOUR FAMILY MEMBER
WITH DOWN SYNDROME:

DATE BY WHICH FUNDS ARE NEEDED: _____

OTHER RESOURCES OF SECURING FUNDS EXPLORED BY FAMILY: _____

HAVE YOU APPLIED FOR CSDSA SCHOLARSHIP FUNDING SINCE JANUARY 1ST OF THIS YEAR?
_____ (YES OR NO) IF YES, IN WHAT MONTH WAS THE REQUEST MADE? _____

FOR MEDICAL SERVICES ONLY:
IS THERE INSURANCE AVAILABLE? _____

IF SO, WHAT TYPE (i.e., HMO, MEDICAID, PPO) _____

IF INSURANCE IS AVAILABLE, WHAT IS YOUR OUT OF POCKET EXPENSE PER VISIT OR PROCEDURE?

WHAT IS THE ANTICIPATED AMOUNT OF OUT OF POCKET EXPENSES FOR THIS REQUEST?

UPON APPROVAL PLEASE MAKE PAYMENT TO:

NAME: _____

ADDRESS: _____

****Please attach receipt if this is a reimbursement**

SIGNATURE

SIGNATURE

Please Mail To: CSDSA, P.O. Box 2364, Colorado Springs, CO 80901