DSAG Scholarship Policy

The Down Syndrome Awareness Group of East Tennessee has established a scholarship fund to provide qualified members with Down syndrome assistance in paying for certain therapeutic activities. These activities may include, but are not limited to, dance, art, horseback riding, water therapy, music or other activities that may build skill, strength and/or self-confidence. Although our budget does not allow DSAG to provide full funding of any one activity, the goal is to provide some funding for as many families as possible.

To qualify for the available funding, an applicant must be a current member of DSAG and reside in one of the following East Tennessee counties: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Hancock, Hawkins, Jefferson, Knox, Loudon, McMinn, Morgan, Roane, Scott, Sevier or Union. You may submit only one application per quarter of each year. Funding will be available on a first-come, first-serve basis. Once the funding has been exhausted, no additional funding will be available until the following year, contingent upon available proceeds. **Priority will be given to those applicants who have a financial need for assistance and have not applied and received proceeds earlier in the year.** Consideration will also be given to whether an applicant is receiving funding from other sources for the particular request. No prepayment of funds will be allowed. Payment will be in the form of either reimbursement with proof of payment being submitted to the DSAG Executive Director or proceeds being forwarded directly to the provider of the service.

Applications for a scholarship may be found in the **March** newsletter, at membership meetings or on the DSAG website at www.dsagtn.org.

Please mail your application to:

DSAG
P. O. Box 53575
Knoxville, TN 37950-3575

Upon request, documentation should be submitted to the DSAG Executive Director providing information on the activity to be attended. Additionally, an explanation will be requested as to how the proposed funding would assist or benefit the applicant with Down syndrome. Please allow two weeks from the date of receipt for a decision to be made on your application.

Scholarships for therapeutic activities will be limited to $200.00 per member with Down syndrome per year.

If the activity is canceled or otherwise refunded, the scholarship funds are required to be returned to DSAG.

DSAG is excited to initiate this new benefit for its members. We realize we cannot make a dramatic impact in funding the needs of our members, but we hope we can make a difference.

We would greatly appreciate your response and input on this scholarship fund and any recommendations you may have concerning how it could better serve our members. If you have any question please call the phone line at (865) 905-2968 and the Executive Director will get back to you as soon as possible.

Disclaimer of Endorsement: DSAG is not endorsing any particular supplier of any therapeutic activity by funding that activity for a DSAG member.
Disclaimer of Liability: DSAG does not assume any liability for any activity funded by this scholarship. Liability remains solely with the participant.

DOWN SYNDROME AWARENESS GROUP OF EAST TENNESSEE
SCHOLARSHIP FUND APPLICATION

DATE SUBMITTED: _____

APPLICANT'S NAME: _____ AGE: _____

PARENT/LEGAL GUARDIAN OF APPLICANT (if applicable): _____

ADDRESS: _____

_____

DAYTIME PHONE: _____ EVENING PHONE: _____

E-MAIL ADDRESS (if available): _____

ITEMS/SERVICES REQUESTED BY APPLICANT: _____

_____

ESTIMATED AMOUNT/COST FOR ITEMS/SERVICES REQUESTED: $_____

OTHER SOURCES OF FUNDING PURSUED AND AMOUNT: _____

_____

(**REMINDER**: DSAG DOES NOT PAY THE APPLICANT DIRECTLY, BUT 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 (attach separate sheet with additional information if necessary):

_____

_____

DATE BY WHICH FUNDS ARE NEEDED: _____

HAVE YOU APPLIED FOR A DSAG SCHOLARSHIP SINCE JANUARY 1ST OF THIS YEAR? (YES OR NO)

_____ IF YES, IN WHAT MONTH WAS THE REQUEST MADE? _____

ANTICIPATED AMOUNT OF OUT-OF-POCKET EXPENSE FOR THIS REQUEST? _____

**Please attach receipt if this is a reimbursement.

UPON APPROVAL, PLEASE MAKE PAYMENT TO:

NAME: _____

ADDRESS: _____

_____ _____

SIGNATURE OF APPLICANT OR LEGAL PARENT/GUARDIAN

PLEASE MAIL TO:
DSAG
P.O. Box 53575
Knoxville, TN 37950-3575