NEW DIRECTIONS™
DOWN SYNDROME ASSOCIATION

FINANCIAL ASSISTANCE PROGRAM

New Directions Down Syndrome Association has funds available to assist families with a variety of expenses that can occur in raising a child/adult with Down syndrome. New Directions wants to be sure that families do not experience unnecessary challenges due to the often high costs of supporting a child/adult with a disability. This program is made possible by funds raised at the Buddy Walk.

Available funding:

- **TRAVEL ASSISTANCE:** This is for out-of-town appointments to cover travel expenses (mileage, meals, lodging and airfare.) Please include a confirmation of the appointment. Reimbursement for expenses will be made after the appointment.
- **MEDICAL BILLS:** This includes hospital or doctor's office bills not covered by insurance and/or the insurance deductible. Please include a copy of the bill.
- **THERAPY BILLS:** This includes physical, occupational, speech, music, vision therapies or other types of therapy not covered by insurance. Please include a copy of the bill.
- **SPECIAL EQUIPMENT:** This includes glasses, hearing aids, orthodontics, orthotics (shoe inserts, remolding helmets, leg braces, etc.), wheelchairs and accessories, and feeding tubes. (This does not include cars, accessible vehicles, wheel chair ramps, bath lifts, or therapeutic toys not covered by insurance.) Please include a copy of the doctor's prescription for the equipment.
- **PRESCRIPTION MEDICATION:** This includes any prescription medication prescribed for your child/adult that is not covered by insurance. Reimbursement for expenses will be made after payment to pharmacy has been made. Please include a copy of the prescription and receipts from the pharmacy showing proof of payment.
- **CONFERENCES AND SEMINARS:** This includes registration fees, airfare, mileage, meals and lodging costs. Please include a copy of the conference/seminar information.
- **ADOPTION FEES:** This includes the adoption fees and childcare costs associated with adoption training. Please include a copy of the adoption fees and childcare costs.

NOTE: To apply for financial assistance, you must be a member of New Directions Down Syndrome Association and live in South Dakota or the area of SW Minnesota or NW Iowa.

PO Box 90712 • Sioux Falls, SD 57109
info@newdirectionsdsa.com

IMPORTANT INFORMATION:

- All applications relating to medical appointment travel assistance, medical and therapy bills, special equipment and prescriptions must be considered a medical necessity by a physician/therapist and must be accompanied by a letter from the primary care physician/therapist.
- Funding is available for the balance remaining after other insurance and/or Medicaid payments have been made.
- Families that do not have insurance, or are self-pay and are applying for assistance with medical bills or therapy bills must apply for Medicaid before assistance is rendered.
- Applicants will be notified if their application was approved and the amount of assistance to be provided.
- Limited funds are available. All applications may not be funded. Requests will be kept confidential.

CHECKLIST — HOW YOU CAN APPLY FOR FUNDING:

» Fill out the application completely and sign it.

» Attach the appropriate documentation for the financial request.

» Return the completed application to:

New Directions Down Syndrome Association
PO Box 90712
Sioux Falls, SD 57109

NEW DIRECTIONS™
DOWN SYNDROME ASSOCIATION

PO Box 90712 • Sioux Falls, SD 57109
info@newdirectionsdsa.com

APPLICATION FORM

PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

APPLICATION DATE: _____

PARENT(S) OR GUARDIAN(S) NAME: _____

NAME OF INDIVIDUAL WITH DOWN SYNDROME: _____ **DOB:** _____ ○ **MALE** ○ **FEMALE**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DAYTIME PHONE: _____ **EVENING PHONE:** _____

EMAIL ADDRESS: _____

NUMBER OF CHILDREN IN THE HOME: _____ **NAMES AND AGES:** _____

HAVE YOU EVER APPLIED FOR ASSISTANCE FROM NEW DIRECTIONS BEFORE? _____ **WHEN?** _____

ASSISTANCE WAS GIVEN FOR: _____ **IN THE AMOUNT OF:** _____

WHAT KIND OF ASSISTANCE ARE YOU REQUESTING FROM NEW DIRECTIONS?	***PLEASE SELECT ALL THAT APPLY:*** ☐ **TRAVEL ASSISTANCE** ☐ **MEDICAL BILLS** ☐ **THERAPY BILLS** ☐ **SPECIAL EQUIPMENT** ☐ **PRESCRIPTION MEDICATION** ☐ **CONFERENCES & SEMINARS** ☐ **ADOPTION FEES**
DOES CHILD/ADULT HAVE DOWN SYNDROME? **DOES CHILD/ADULT HAVE ANY OTHER DIAGNOSES?**	○ **YES** ○ **NO** ○ **YES** ○ **NO**
NAME OF PRIMARY PHYSICIAN(S)	_____
DO YOU HAVE INSURANCE?	○ **YES** ○ **NO** ***IF YES, WHAT COMPANY?*** _____
DO YOU HAVE MEDICAID?	○ **YES** ○ **NO** ○ **DENIED** ***IF DENIED... WHY?*** _____ ***IF NO... HAVE YOU APPLIED FOR MEDICAID?*** ○ **YES** ○ **NO**
ARE YOU RECEIVING ANY FINANCIAL ASSISTANCE FROM OTHER PROGRAMS? (FAMILY SUPPORT, BIRTH TO THREE, ETC.)	○ **YES** ○ **NO** ***IF YES... FROM WHICH PROGRAM AND HOW MUCH?*** _____ _____

Medical or Therapy Assistance – complete this section:

PLEASE INCLUDE A COPY OF THE MEDICAL BILLS NOT COVERED BY INSURANCE OR A COPY OF THE THERAPY BILLS.

NAME OF CLINIC/HOSPITAL/THERAPIST _____

ADDRESS OF CLINIC/HOSPITAL/THERAPIST _____

NEW DIRECTIONS™
DOWN SYNDROME ASSOCIATION

PO Box 90712 • Sioux Falls, SD 57109
info@newdirectionsdsa.com

Travel Assistance – complete this section:

PLEASE INCLUDE A CONFIRMATION OF THE APPOINTMENT FROM THE OUT OF TOWN PHYSICIAN.

NAME & ADDRESS OF OUT-OF-TOWN PHYSICIAN _____

_____

APPOINTMENT DATE _____ **EXPECTED LENGTH OF STAY** _____

Transportation:

NUMBER OF MILES ROUND TRIP _____ **X $.50 =** _____ **AIRFARE COST** _____

PARKING FEES $ _____ **TAXI FARE $** _____ **SHUTTLE FARE $** _____ **OTHER $** _____

Meals:

PLEASE INDICATE THE NUMBER EATING: THE AMOUNT INDICATED PER MEAL PER PERSON WILL BE REIMBURSED.

BREAKFAST - # _____ **X $ 5.00 =** _____ **LUNCH - #** _____ **X $ 9.00 =** _____ **DINNER - #** _____ **X $12.00 =** _____

Lodging:

LODGING: ACTUAL COST $ _____ **X** _____ **NIGHTS = $** _____

Special Equipment – complete this section:

PLEASE INCLUDE A PRESCRIPTION FOR THE EQUIPMENT FROM THE PHYSICIAN.

WHAT PIECE OF EQUIPMENT ARE YOU REQUESTING? _____

HOW LONG WILL THE EQUIPMENT BE USED? _____ **PRICE QUOTE $** _____

WHY IS THIS EQUIPMENT BEING REQUESTED? _____

Prescription Medication – complete this section:

PLEASE INCLUDE A COPY OF THE PRESCRIPTION AND THE RECEIPTS FROM THE PHARMACY SHOWING PROOF OF PAYMENT.

PHARMACY NAME _____

Adoption Fees – complete this section:

PLEASE INCLUDE A COPY OF THE ADOPTION FEES AND CHILDCARE COSTS..

NAME & ADDRESS OF ADOPTION AGENCY _____

CONTACT PERSON _____ **ADOPTION FEES:**

CHILDCARE COSTS FOR ADOPTION TRAINING _____

NEW DIRECTIONS™
DOWN SYNDROME ASSOCIATION

PO Box 90712 • Sioux Falls, SD 57109
info@newdirectionsdsa.com

Conference/Seminar Fees – complete this section:

PLEASE INCLUDE A COPY OF THE CONFERENCE/SEMINAR INFORMATION.

GUIDELINES: Reimbursement will be up to $500 for the first adult family member and up to $250 for all other family members, up to 3 more family members. (Immediate family only.) Conference fees will be reimbursed at 50% before the conference and 50% after the conference. A letter of agreement will need to be signed stating that if money is not used for the intended purpose the money will be repaid to New Directions. All receipts will need to be turned in upon completion. Families will share experience with other New Directions families per the guidelines stated in the letter of agreement.

TITLE OF EVENT: _____ **DATE(S) OF EVENT:** _____

LOCATION: _____

NAME(S) OF ATTENDEE(S): _____

HAVE YOU ATTENDED THIS CONFERENCE BEFORE? ○ **YES** ○ **NO** **IF YES, WHEN DID YOU LAST ATTEND? DATE:** _____

WHY DO YOU WANT TO ATTEND THIS CONFERENCE/SEMINAR? _____

_____

Registration:

REGISTRATION FEES _____

Transportation:

NUMBER OF MILES ROUND TRIP _____ **X $.50 =** _____ **AIRFARE COST** _____

PARKING FEES $ _____ **TAXI FARE $** _____ **SHUTTLE FARE $** _____ **OTHER $** _____

Meals: PLEASE INDICATE THE NUMBER EATING: THE AMOUNT INDICATED PER MEAL PER PERSON WILL BE REIMBURSED.

BREAKFAST - # _____ **X $ 5.00 =** _____ **LUNCH - #** _____ **X $ 9.00 =** _____ **DINNER - #** _____ **X $12.00 =** _____

Lodging:

LODGING: ACTUAL COST $ _____ **X** _____ **NIGHTS = $** _____

PLEASE READ AND SIGN BELOW

I GUARANTEE THAT THE INFORMATION IN THIS REQUEST FOR FUNDING TO BE ACCURATE, COMPLETE AND TRUE.
I UNDERSTAND THAT ALTERING THIS APPLICATION OR PROVIDING FALSE INFORMATION IN ANY WAY WILL RESULT IN DENIALOF THIS REQUEST.

TOTAL AMOUNT REQUESTED: $ _____

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____

NEW DIRECTIONS™
DOWN SYNDROME ASSOCIATION

PO Box 90712 • Sioux Falls, SD 57109
info@newdirectionsdsa.com