D.R.E.A.M.

Down syndrome Research Education Advocacy in Montana

GRANT APPLICATION FORM

Please read the grant guidelines then fill in all information requested.

Date of application: _____

Applicant's name:_____

Address:_____

City _____State_____ZIP_____

Telephone: (home) _____ (work) _____ (cell) _____

E-mail: _____

Child's name (if applicable):_____

Child's date of birth: _____

Applicant's relationship to child *(circle one):*

Parent Foster parent Sibling Guardian Other

If *Other* is circled, please explain the relationship:_____

How did you hear about DREAM: _____

_____

Please describe the medical treatment/services for which you are applying for funds:

_____

_____

_____

Services amount requested: _____

Please describe the equipment for which you are applying for funds and its intended use:

_____

_____

_____

Equipment amount requested: _____

(over)

Please describe the travel expenses of lodging, airfare, or mileage (50 cents per mile) for which you are applying for funds:

_____

_____

_____

Travel expense amount requested: _____

Total amount requested: _____

I have read the grant guidelines and I and/or my child complies with all requirements.

_____ _____

Signature of Applicant Date

Please include receipts or documentation from the provider for all expenses for which you are applying for funding. Please provide an insurance Explanation of Benefits (EOB) ***and*** *a billing statement, if applicable. Return completed application to:*

DREAM
PO Box 6051
Bozeman, MT 59771

Received: _____ Approved: _____