# Education Scholarship Program Application

Please review the DSACO Education Scholarship Guidelines prior to submitting your request.

*Please print clearly or type*

Participant Name: _____ Birth date: / /

Parent/Guardian Name: _____

Street Address: _____

City: _____ Zip Code: _____ County: _____

Phone: ( ) _____ Email: _____

Intended use of funds: _____

Cost of activity/purchase: _____ **Please attach a copy of the receipt

If applicable: Begin date of activity: / / End date of activity: / /

Provider's Name: _____

Provider's Address: _____

Would you recommend this activity/purchase to other parents? YES NO___(circle one)

Please explain: _____

_____

_____

_____

Have you requested funds previously? YES NO (circle one) If yes, when: / /

Parent/Guardian Signature: _____

**Participants are eligible to receive up to $200 annually between January 1 – December 31. Please call the DSACO office at (614) 263-6020 if you have any questions regarding your scholarship balance for the current fiscal year. Funds are awarded on a first applied, first accepted basis.

Mail completed application and copy of receipt to:

**Down Syndrome Association of Central Ohio**

**510 E. North Broadway, 4th floor**

**Columbus, OH 43214**