HealthCare Coordination Scholarship Program Application

To determine eligibility and appropriateness of service request, please review the DSACO HealthCare Coordination Scholarship Guidelines prior to submitting your request.

Please print clearly or type

Family Member Names: _____

Street Address: _____

City: _____ Zip Code: _____ County: _____

Phone: ( ) _____ Email: _____

Purpose of requested services: _____

_____

_____

Have you applied for this scholarship previously? YES NO (circle one) If yes, when: / mm/yy)

Disclaimer: *In collaboration with DSACO, the CarePartner team members may request the minimum necessary information to assist you and your family with benefits, claims, and billing disputes. This may include copies of your summary of benefits, online insurance portal information, billing invoices, explanation of benefit statements, etc. CarePartner will make a determination in our initial phone call about what information is pertinent to help you most efficiently. CarePartner is bound by all HIPAA and Protect Healthcare Information regulations, so please know that your information will be handled with extreme care per the oversight of their Internal Compliance Officer.*

☐ I understand and accept the above disclaimer.

Parent/Guardian Signature: _____ Date: _____

* Funds are awarded on a first applied, first accepted basis. Applications may be waitlisted due to program capacity restrictions.

Mail completed application to:
Down Syndrome Association of Central Ohio
510 E. North Broadway, 4th floor
Columbus, OH 43214
OR
Email your completed application to:
info@dsaco.net and enter "HealthCare Coordination Scholarship" in the subject line.