heart of illinois Down Syndrome Association

c/o Bethel Lutheran Church ◆ 325 E. Queenwood Road ◆ Morton, Illinois 61550 ◆ 309-363-3125

Inclusive Activity Stipend

Purpose and Eligibility: The purpose of the stipend is to help encourage and support the participation of persons with Down syndrome in activities within the community along with typically developing peers. Stipends are limited to persons that that reside within HOIDSA's service area in Central Illinois (Peoria, Marshall, Tazewell, and Woodford counties).

Donor: Heart of Illinois Down Syndrome Association (HOIDSA)
Amount: Up to $100 per person with Down syndrome - limited to ONE stipend per calendar year

Background: The Heart of Illinois Down Syndrome Association, Inc. (HOIDSA) is a local support group of parent volunteers funded through donations and fundraising activities. We formed in the 1980's and were established as a 501(c)(3) organization in 2003. We operate under the oversight of a Board of Directors.

HOIDSA Goals:

- To offer support and information to help families adjust to the special needs of a child with Down syndrome
- To promote public awareness and increased understanding of Down syndrome
- To help improve the quality of life of individuals with Down syndrome
- To integrate persons with Down syndrome into all aspects of educational and community life
- To serve as advocates for ALL

Application Process:

1. Thoroughly complete application form below, and either mail to HOIDSA's mailing address or email to dianna.shoemaker@yahoo.com. Incomplete applications will not be considered.
2. Application and activity receipt will be reviewed by the Treasurer
3. HOIDSA will then mail a check directly to the applicant to reimburse them for their purchases (up to $100 per person with Down Syndrome per calendar year).
4. Deadline: December 1 for current calendar year

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Applicant's Name:_____

Mailing Address:_____

School Phone: _____

Email Address:_____

Please describe the activity that the person with Down syndrome will be participating in:

_____
_____
_____
_____
_____
_____
_____
_____

Total Cost of the Activity:_ _____ (please submit receipt with application)

Amount Requested:_ _____ (max $100 per calendar year)

_____ _____ *By signing, you acknowledge that the information within the application is correct to the best of your knowledge

Date

Mission: Improving the quality of life of persons with Down syndrome by providing support, advocacy and educational opportunities to those individuals, their families, and community advocates.

Vision: Impacting the community by empowering members, expanding partnerships and promoting awareness through focused and responsive growth.