



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 \$400 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](mailto: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 \$400 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:

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

Amount Requested: \_\_\_\_\_ (max \$400 per calendar year)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

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

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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.