Down Syndrome Community of Greater Chattanooga Medical Helper Grant

The Down Syndrome Community of Greater Chattanooga (DSCGC) Medical Helper Grant assists in providing needed services for family members with Down syndrome. Children and adults with Down syndrome have an increased risk of medical problems, need for intense weekly therapies, and supplemental nutrition. Unfortunately, insurance plans often do not cover many of the necessary treatments. The Medical Helper was developed as a financial aid tool for families that need it most. The program helps families pay for medical services that are used to treat individuals diagnosed with Down syndrome.

Although the Medical Helper Program is limited, the goal is to provide funding to offset the cost of medical expenses related to the diagnosis of Down syndrome. These expenses might include but are not limited to specialized provider appointments, physical therapy, occupational therapy, speech and feeding therapy, and certain medications not covered under insurance co-pays and/or hospitalizations. The program does not fund co-payments or premiums to the insurance company.

Applicants must meet the following basic criteria to apply:

Any individual with Down syndrome residing in the DSCGC service area-

TN counties: Hamilton, Bradley, Bledsoe, Marion, Polk, Rhea, Sequatchie

GA counties: Catoosa, Chattooga, Dade, Gordon, Murray, Walker, Whitfield

AL counties: Cherokee, DeKalb, Jackson

Diagnosis of Down syndrome, not limited to age

Annual Maximum:

The maximum scholarship per individual family per fiscal year is $500. DSCGC fiscal year for this grant begins on January 1 and ends on December 31. The program is based on application submission followed by voting of the DSCGC Board members.

Application Process:

1) Requestor must complete the DSCGC Medical Helper application
2) Requestor must submit a copy of the paid receipt with application. DSCGC will reimburse for actual expenses. If the requestor has an outstanding bill, payments will be made to provider only. Applications submitted without receipt of payment will be considered incomplete and will not be processed.
3) Please provide a copy of the actual bill with statement of insurance payment. This can be a statement issued after insurance has paid and noted on the statement the remaining balance or your insurance company's EOB.
4) Requests must be submitted within 60 days of billing and mailed to the following address:

DSCGC
P.O. Box 4891
Chattanooga, TN 37405
or email grants@chattanoogadownsyndrome.org

Awarding funds:

After an application is approved, payment will be processed within 30 days of the monthly DSCGC Board meeting. Once you have received notification, you may contact your service provider to notify them of pending payment from DSCGC if necessary. If the application is denied, a brief explanation will be included in the written notification. Requests may be denied for, but not limited to, the following reasons:

1) Requestor has already been awarded the annual maximum of $500
2) Service is not classified as a medical expense
3) Applicant resides outside the DSCGC service area
4) Medical Helper funds have been exhausted for the current fiscal year.
5.) More than 60 days have lapsed since billing date.

Please email grants@chattanoogadownsyndrome.org if you have any questions.

Down Syndrome Community of Greater Chattanooga
Medical Helper Application

Please print clearly

Participant's Name: _____Date of Birth: ___/___ /___ mm/dd/yy

Parent or Guardian's Name:_____

Street Address_____

City:_____State: _____Zip Code:_____

County:_____ Phone (____)_____Email:_____

Please briefly explain need for Medical Helper:_____

_____

_____

_____

Date of expense: From ____/____/____ mm/dd/yy To : ____/____/____ mm/dd/yy

Cost of expense: $_____ *please attach copy of receipt to application

Is payment to provider? _____If yes, due date for payment ___/___/___ mm/dd/yy

***copy of written statement or EOB must be attached to application**

Have you applied for/received funding from other sources relating to this request? _____ If yes, where? _____

Provider Name _____

Provider's Address_____

Provider's City_____ State_____ Zip: _____

Phone:_____

Parent/Guardian Signature: _____Date: ____/____/____

Mail completed form and all requirements to: DSCGC, P.O. Box 4891, Chattanooga, TN 37405 or email to grants@chattanoogadownsyndrome.org