DSAmd | DOWN SYNDROME ASSOCIATION OF MARYLAND

PO Box 20127 Baltimore, MD 21284
410.321.5434 | info@DSAmd.org
www.DSAmd.org/Events

Amanda-Hope Medical Assistance Program

About the Fund

The Amanda-Hope Medical Assistance Fund was established by DSAmd (then CDSPG) in 2014 after two young children in our community were diagnosed with acute lymphoblastic leukemia. The challenges for these families are tremendous —both emotionally and financially—with long hospitalizations, countless days spent in clinic, and parents and siblings worried and stretched thin. CDSPG's support for these children and their families through the Amanda-Hope Fund provides both monetary assistance to help make up for lost wages and medical expenses as well as the reassurance that they are remembered by our community during this difficult time.

Eligibility Guidelines

The fund was created to provide financial assistance to families of children with Down syndrome diagnosed with leukemia (AML or ALL) who live in Maryland (with exceptions at the discretion of the Board). Grants to families are made any time during a child's treatment. Grants are not made on the basis of financial status of the family, and will be awarded based on availability in the fund with the amount to be determined by the Board of Directors.

Application Process

Families may self-refer by filling out an application including verification of the diagnosis by their child's physician, or families may be referred by a friend or family member. In the case of a referral by a friend or family member, the Amanda-Hope Fund Committee will follow up with the family to complete the necessary application. Referrals and completed applications and referrals should be sent to Down Syndrome Association of Maryland - DSAmd., Attn: Amanda-Hope Medical Assistance Fund, P.O. Box 20127, Baltimore, MD 21284-0127, or emailed to info@DSAmd.org

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Application

Child's name _____Date of birth _____

Address_____

City _____ State _____ Zip _____

Phone _____

E-mail address _____

Parent 1/Best contact: _____

Parent 2/Best contact:_____

Physician's name: _____

Treating hospital _____

City _____ State _____

Phone _____

E-mail address _____

Diagnosis _____

Date of Diagnosis _____

I verify that the above-named child has Down syndrome and is in treatment for leukemia.

Signature _____Date _____

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