FAMILY MEDICALGRANT APPLICATION
January 1, 2021-March 31, 2021

Guardian Name____Date_______________________

Member Name: ______________________________________ Date of Birth: ___________________

Address____

City______________________________State_______________Zip______

phone___________________ Email____

DSAV Volunteer Hours (2019-2020):

Activity_____________________________________ date_____________ number of hours____________

Activity_____________________________________ date____________ number of hours____________

Provider(s) Information: **(Checks will be made to the provider(s) of service/activity and mailed to the DSAV member's home address)**

Provider #1 - Check Made Payable to____

Address____

Amount of Request (Max $500) _______________

Provider #2 - Check Made Payable to____

Address____

Amount of Request (Max $500) _______________

Complete application and submit to DSAV

DSAV
945 Boardman-Canfield Road, Ste. 12
Boardman, OH 44512
Email: office@dsav.org

Office Use Only

Check #: __________

Amount: __________

Date: __________