FLOWER CITY
DOWN SYNDROME NETWORK

Serving the Greater Rochester Area Since 1991

Media Reimbursement Application

Before applying, please refer to the "FCDSN Reimbursement Program Policies"

Member Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Reimbursement is requested for the following:

Name of Individual with Down syndrome: _____

Title: _____

Publisher: _____

Cost: $ _____ ____Book ____CD ___DVD ____Video

Title: _____

Publisher: _____

Cost: $ _____ ____Book ____CD ___DVD ____Video

Title: _____

Publisher: _____

Cost: $ _____ ____Book ____CD ___DVD ____Video

Total reimbursement requested: $ ☐

Signature of person completing form: _____ Date: _____

Original receipts are required prior to disbursement of funds. Keep a copy of your receipts and this submission for your own records. Submit complete (signed) application, with original receipts, to:

FCDSN Reimbursement Programs, 2117 Buffalo Road #132, Rochester, NY, 14624

Do Not Write In Box Below

Member in good standing? ☐ Yes ☐ No Verified by: _____

Application: ☐ Approved ☐ Denied/Reason: _____

Reply Mailed On: _____ Check # _____ Amount: $_____

Entered: ☐ Date: _____

Jan-16