Name of Event\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Event\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*You may submit more than one request per year however,*

*priority will be given to those who have not yet received personal*

*development grant funds within the current calendar year.*

Grants are intended for the use of individuals, families and providers to assist the individual and/or his/her family to participate in events and activities that foster integration and community Inclusion. A certified independent provider may also request grant dollars for specific training relating to an individual served within Auglaize County.

This reimbursement request form must be received 30 days prior to the event. Reimbursement is not guaranteed. Email completed reimbursement request along with event information or a link to the event to Leslie West lwest@auglaizedd.org or mail to: Auglaize DD, Attn: Leslie, 20 East First St., New Bremen, OH 45869. Questions? Call (419) 629-1502 Ext. 101 (8 a.m. – 4 p.m. weekdays)

You will be contacted by no later than ten (14) days after we receive the application with the approval status. You will then need to submit a copy of your receipt of payment and/or registration confirmation to lwest@auglaizedd.org. Reimbursement will be processed within thirty (30) days of receiving a copy of your receipt of payment and/or a copy of your registration confirmation.

1. [ ] **Agency** [ ] **Independent Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Address:**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_

1. **Telephone Number(s)**

(\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Email**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you received funds from the Auglaize DD personal Development Grant program in the past 12 months?**

[ ] Yes [ ] No.

***Please select one of the following.***

[ ]  **Training** [ ]  **Individual accompaniment to event** [ ]  **Supplies for Individual Served** [ ]  **Other**

**If Supplies or Other Please explain.**

1. **How is this relevant to the individual as it pertains to the goals in their ISP? (If seeking reimbursement for training cost please disregard)**
2. **Cost Reimbursement Requested**

[ ] Event Registration $\_\_\_\_\_\_\_\_\_ [ ] Hotel $\_\_\_\_\_\_\_\_\_ [ ] Supplies $\_\_\_\_\_\_\_\_\_\_

[ ] Other $\_\_\_\_\_\_\_\_\_\_

1. **Certification Statement**

By signing my name below, I confirm that all of the information provided above and in the accompanying documents (if any) is true and correct to the best of my knowledge. I also understand that if approved I must pay all registration fees and provide supporting documentation of such payment prior to receiving payment of said reimbursement.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

[ ]  Approved [ ] Denied

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Renee Kohler Date

Superintendent, Auglaize DD