

**The Family Center for Children and Youth with Special Health Care Needs
Conference Scholarship
Parent/Youth Application**

Who is applying: Parent (of a child, birth to 26) Youth (14 yrs. to 26 yrs.)

Parent Name: _____

Youth Name: _____ Child/Youth Birthdate: _____

Address: _____ City: _____ Zip code: _____

County: _____ Daytime Phone: () _____

Email Address: _____

Name of Conference: _____

Dates: _____ to _____ Location (City, State): _____

1. What is your/your child's diagnosis? _____
2. Has your family received a conference scholarship from the Family Center in the past?
 No Yes Date attended: _____
3. Have you ever attended a conference related to your diagnosis (youth) or your child with special needs diagnosis, condition, or treatment?
 No Yes Date attended: _____
4. Have you applied for any funding/scholarships to attend this conference other than the Family Center scholarship? If so, what expenses will it cover?
 No Yes Expenses covered: _____
5. How will attending this conference help your family? (Please feel free to use the back of this page for more space)

Submit your completed application to one of the following:

1. **Email:** Egglestona@michigan.gov
2. **Fax:** 517-241-8970
3. **Mail:** Family Center for Children and Youth with Special Health Care Needs
Michigan Department of Health and Human Services
P.O. Box 30734
Lansing, MI 48909

If you need further help, please contact Ayanna Eggleston, 517-335-8551 or Family Phone Line, 800-359-3722.

Conference Scholarship Budget Worksheet – (In Person only)

Please complete the *Budget Worksheet* and *Proposed Budget* form and submit with your application.

Registration

Name of Conference	Registration Cost	Total (if discount given, cost after discount)
		\$

Mileage *Please provide a MapQuest or similar printout showing distance from home to event.

Miles from Home to Event	Multiply	Round Trip Miles	Multiply	Reimbursement Rate	Total
	X 2	=	x	\$ 0.67	\$

Other Transportation Expense

Travel Date	Type of Transportation Plane/Taxi/Bus/Train/Parking/Tolls	Explanation of Need	Total
			\$
			\$
Total:			\$

Lodging/Hotel *Check for conference discounts (distance from home must exceed 100 miles)

Dates	Name and Address of Hotel	Phone Number Of Hotel	Number of Nights	Amount per Night	Additional Fees or Tax	Total
				\$	\$	\$

Meals *Meals will be verified per agenda/hotel.

Maximum Allowed per Meal	In state	Out of state	Dates meals needed	Total
Breakfast	\$9.75	\$11.75		\$
Lunch	\$9.75	\$11.75		\$
Dinner	\$22.00	\$27.00		\$

Childcare - Rates not to exceed \$525.00 per conference.

Private Duty Nursing (PDN) - Rates not to exceed \$700.00 per conference.

	Start Date/Time	Ends Date/Time	Total Days	Rates for childcare and PDN	Total
Child Care				\$20 /hr., up to a maximum of \$75/day	\$
PDN				\$150.00 per day	\$

Conference Scholarship Proposed Budget (In-Person Only)

Please check all boxes that apply, provide necessary details, and total dollar amount requested for each item.

Conference registration	One parent (of a child, birth to 26)	\$
	One youth (14 yrs. to 26 yrs.)	\$

Transportation & Lodging

Roundtrip airfare	One parent (of a child, birth to 26)	\$
	One youth (14 yrs. to 26 yrs.)	\$

Mileage reimbursement at **\$0.67 cents** x _____ **miles** \$

Parking fees and Tolls \$

Ground transportation (taxi, bus, shuttle) \$

Lodging: \$ _____ per night x _____ number of nights \$

(Please remember to include taxes)

Other

Meals (See worksheet and state rates sheet enclosed) \$

Childcare (See worksheet to calculate total allowed) \$

Private Duty Nursing (PDN) (See worksheet to calculate total allowed) \$

Other requested expenses (ex. Wheelchair rental, seat extenders etc.) \$

TOTAL AMOUNT REQUESTED — this is the total amount of the conference.

\$

Reimbursement: Please choose which choice you prefer

\$

Travel Advance—Receive a check for half of the **approved** conference costs in advance.

- Applications received after the **90-day deadline** do not qualify for a travel advance. Receipt confirming registration must be received before a travel advance can be granted.

Total Reimbursement—Receive a check for the full **approved** conference costs after attending the conference.

***Childcare must be provided by someone who does not live within the home. For example, a spouse does not qualify for childcare reimbursements.**

Only pre-approved conference costs will be reimbursed.

Please attach conference brochure or agenda, confirming dates and conference registration fees

Conference Scholarship Proposed Budget (Virtual only)

Please attach conference brochure or agenda, confirming dates and conference registration fees

Please check all boxes that apply, provide necessary details, and total dollar amount requested for each item.

Registration Fees

Conference registration	One parent (of a child, birth to 26)	\$
	One youth (14 yrs. to 26 yrs.)	\$

Other Cost

Childcare - See worksheet to calculate total allowed	\$
Private Duty Nursing (PDN) - See worksheet to calculate total allowed	\$

TOTAL AMOUNT REQUESTED —this is the total amount of the conference.

\$

Total Reimbursement – Receive a check for the full **approved** conference costs **after** attending the conference.

Virtual Conferences will not qualify for a travel advance due to the requirement of registration having to be prepaid for a travel advance to be issued.

***Childcare must be provided by someone who does not live within the home. For example, a spouse does not qualify for childcare reimbursements.**

Only pre-approved conference costs will be reimbursed.

Please attach conference brochure or agenda, confirming dates and conference registration fees