

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES



DDS Stipend Request Form

Directions for completing this form:

1. The person requesting the stipend should fill out this form, with his or her name, address, date, and information on the meeting or activity attended and stipend being requested.
2. The form must be submitted to the DDS staff liaison to the Committee within two weeks of attending the meeting.
3. The DDS staff liaison to the Committee shall co-sign the form and is responsible for submitting it to the assigned Administrative Specialist for processing within one week of receipt.

Name: _____ Date: _____

Address: _____

Stipends are subject to a maximum of \$50 per person, for each meeting, except that a person may be eligible for an additional child care stipend of up to \$50 per person, per meeting. A person may receive up to \$600 per year in stipends. Stipends are only available for people who are not employed full time, people who forfeit wages to attend the meeting, or who incur additional transportation or childcare expenses that would cause a hardship.

I request a stipend for participation at the following DDS Committee or activity:

- Developmental Disabilities Administration (“DDA”) Advisory Committee
- DDA Advocates Policy Review Group
- DDA Policy Review Group
- Human Rights Advisory Committee
- Mortality Review Committee
- Quality Improvement Committee
- Restrictive Controls Review Committee
- State Rehabilitation Council
- Statewide Independent Living Council
- Supporting Families Community of Practice activities
- Other: _____

Date of activity: _____

I request a stipend for (check all that apply):

- Travel (\$10 flat rate)
- Participation (including preparation time for people with intellectual disabilities):
 - 1 hour meeting: \$10
 - 2 hour meeting: \$20
 - 3 hour meeting: \$30
 - 4 hour meeting: \$40
 - 5 hour meeting \$50
- Child care (\$10/ hour) for _____ hours (include meeting and transportation time, up to 5 hours).

Signature of Person Requesting Stipend

Date

I confirm that the person attended the meeting for _____ hours.

DDS Staff Who Chairs/ Facilitates the Meeting

Date

Printed Name

Title

I approve \$_____ in stipends.

DDS Deputy Director

Date