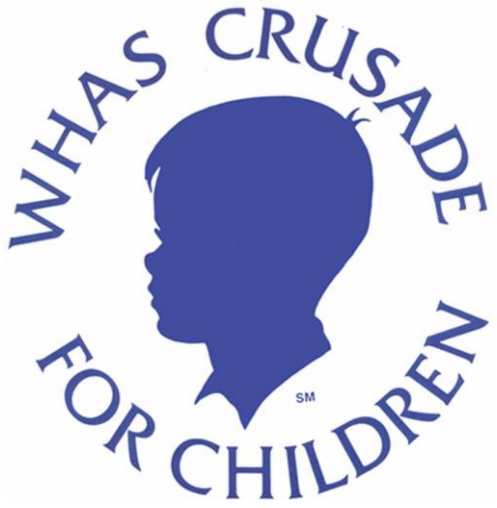
SPINA BIFIDA ASSOCIATION OF KENTUCKY

Financial Assistance Fund Application



WHAS helps support the SBAK Financial Assistance Fund.

Dear Applicant:

The Mission of the Spina Bifida Association of Kentucky is to create a better and brighter future for all those impacted by spina bifida. As part of this mission, the Spina Bifida Association of Kentucky has developed a Financial Assistance Fund to help individuals affected by spina bifida lead better lives by assisting in various areas, from education to physical needs.

Please find, included in this application, the areas in which we would like to assist as well as the process of applying. The fund is small. As we reach out into the community to raise awareness and dollars, we are confident we will be able to grow our Financial Assistance Fund and be in the position to help more individuals and increase the dollars granted. Please do not get discouraged in your application is not fully funded. Fundraising events throughout the year help support all the FREE programs and services offered by the Spina Bifida Association of Kentucky including the Financial Assistance Fund, but the Walk-n-Roll is our largest fundraiser and awareness event. In recent years SBAK has expanded the Walk event to encompass multiple cities across the state, but even more importantly there is a virtual aspect to this fundraiser which makes it possible for EVERYONE to participate. It is our hope that the WNR will garner more participation and support and the Financial Assistance Fund will flourish to better serve our community so that they too, may thrive. Please apply and clearly state your need.

The Spina Bifida Association of Kentucky looks to its own members and friends of the association to help raise awareness and dollars for our Financial Assistance Fund. If you or any member of your family works for or knows of an employer that has a matching gift program, a foundation, a grant application process, or may be interested in sponsoring or partnering with SBAK for a program or event, please notify Doug Dressman, Executive Director at (502) 637-7363.

Thank you for your application. We look forward to hearing from you.

On behalf of the children, their families, and the adults we serve,

Doug Dressman
Executive Director

Financial Assistance Fund

Categories for Financial Assistance

- Medical & Therapeutic Expenses
- Durable medical equipment
    - Wheelchairs, standers, walkers, crutches, braces, equipment for adapting the home
- Recreational equipment: i.e., hand-cycles, sport-chairs
- Continuing Education Scholarships
- Educational/Medical conferences and/or seminars
- Children's camp opportunities
- Transition to Independence Specialized Programs
- Vehicle Modification

General Guidelines for Financial Assistance

- Through this application process, a designated committee will determine if there is a vital need and true financial hardship.
- Monies are given for the direct benefit of the individual affected by spina bifida
- Applicant needs to prove that he or she (or parent (s)) cannot pay for this request themselves
- Monies are never paid to an individual. Monies are paid directly to suppliers, camp, school, etc.
- Required documentation must be from medical professional, equipment company, conference or seminar, camp etc.
- Monies are given for one-time events/situations
- No medications are covered
- Applicants need not be members of SBAK; however, the applicant should live in or near our service area (The state of Kentucky or Southern Indiana). All monies granted will have a purpose that supports the Spina Bifida Association of Kentucky's mission.
- All monies granted will be in accordance with generally accepted accounting principles (GAAP) and will be audited in accordance with generally accepted auditing standards (GAAS) by an independent CPA.

Steps for Financial Assistance Request

1. Applicant fills out application.
2. Include necessary information:
    a. Letter from medical professional/therapist stating new equipment is needed (mandatory for education and medical equipment).
    b. Letter from medical professional/therapist stating new or additional therapy is needed.
    c. Letter from medical professional stating new or repeat medical procedure is needed.
    d. Letter from medical professional stating any new diagnosis or condition relating to the request for funds.
    e. Proof of cost is provided:
        i. Equipment brochure/invoice/quote
        ii. Medical procedure/medical supplies – invoice/quote
        iii. Camp or seminar – literature with pricing
        iv. Vehicle modification quote
    f. Proof of household income – income taxes, SSI, how many in household (income tax and SSI are mandatory upon request).
3. Mail application and attached information to:

    Spina Bifida Association of Kentucky
    982 Eastern Pkwy, Box 18
    Louisville, KY 40217

    Or

    Email your application to Sarah Richardson at srichardson@sbak.org

4. SBAK staff may contact you if additional information is needed.
5. Application is presented to the Committee.
6. Committee reviews.
7. Designated Staff (On-Call Consultant) contacts family or individual.
8. If funds are approved, SBAK pays provider, school, camp etc. directly

APPLICATION

Financial Assistance Fund for Medical, Recreational and Independent Living Needs Application

Application Date _____

Name of individual _____Date of Birth _____

Parent or Guardian_____

Address _____ City _____ State _____

Telephone: Home: _____Cell: _____

Best Time to Call: _____

Email: _____

Are you active with SBAK ____ Yes ____ No

If yes, when did you last participate? _____What programs or events have you attended?

_____

_____

_____

_____

How did you hear about the Financial Assistance Fund?

_____

_____

Have you been supported/helped by the Financial Assistance Fund in the past? _____Yes _____No.
If Yes, please describe how and when you were helped.

_____

_____

_____

Please describe how the item/assistance you are requesting will increase function and benefit you in the community and/or at home as it pertains to Spina Bifida?

_____

_____

_____

_____

_____

_____

_____

1. Medical Request for medical expenses, equipment, or therapy
Please attach documents supporting the request.

- **Doctor's or Physical Therapist's prescription for the item or service.**
- **Cost of the item or service.**
- **Denial of coverage by insurance**

Describe the item or service:

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2. Conference or Training Request: Request for funds to attend a conference or training. Please attach a brochure or description of the conference or training and any related expenses such as rooms or meals.
Has SBAK assisted you with expenses for a conference or training in the past? _____ Yes _____ No
If yes, when?

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3. Daily Living or Recreational Request: Request for funds to enhance or support independent living or recreational activities. Please describe the equipment, such as a lift or a wheelchair for basketball. Include the cost. Attach a picture if available. Include brochures for recreational camps or training seminars.

Do you have another source to help with this expense if this request is denied? ____No ____ Yes
If Yes, please explain

Have you applied for any other assistance programs or grants to fulfil your request? (Churches, nonprofits, state grants, etc.) _____ No _____ Yes
If Yes, please explain
_____

Will you create and participate in the SBAK Walk-n-Roll (WNR) to create awareness and help raise vital funds for our FREE programs and series, including the Financial Assistance Fund? _____ No ____ Yes

Family Income (additional proof may be requested)

$ _____ Wages/Pay Parent $ _____ Wages/Pay (others in household)

$ _____ Unemployment $ _____ Disability Assistance

$ _____ Worker's Compensation

$ _____ Social Security $ _____ Child Support

Total Income _____

Number of Family Members Living at the same Address _____ Adults ____ Children

Outstanding medical expenses

Outstanding living expenses

Other information that you wish to share with the committee

Funds available are limited. I understand that the decision of the committee is final.

Signature of Individual or Parent _____

Date _____

Information provided on this application form is confidential. The written permission of the adult applicant or the parent/guardian of a child applicant is required for information to be shared with another agency, professional or provider. Applications will be retained by SBAK for two years.