SPINA BIFIDA ASSOCIATION OF KENTUCKY

Financial Assistance Fund Application

Financial Assistance Fund

Categories for Financial Assistance

- Medical & therapeutic expenses
- Durable medical equipment (wheelchairs, standers, walkers, crutches, braces, equipment for adapting the home, etc.)
- Recreational equipment: hand-cycles, sport-chairs, etc.
- Continuing education scholarships
- Funds to attend educational/medical conferences and/or seminars
- Fees to attend children's camp opportunities
- Transition to Independence Specialized Programs
- Vehicle modification

General Guidelines for Financial Assistance

- Monies are given only for the direct benefit of the individual with spina bifida
- Applicants need to prove that they (or parent (s)) cannot pay for this request themselves. A designated committee will determine if there is a vital need and true financial hardship
- Monies are never paid to an individual, only directly to suppliers, camp, school, etc.
- Required documentation must be from a 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 the Kentucky/Southern Indiana service area.
- 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. Fill out the application, including any necessary information as applicable:
    a. Letter from a medical professional stating new equipment is needed (mandatory for education and medical equipment).
    b. Letter from a medical professional stating new or additional therapy is needed.
    c. Letter from a medical professional stating new or repeat medical procedure is needed.
    d. Letter from a medical professional stating any new diagnosis or condition relating to the request for funds.
    e. Proof of cost must be provided as follows:
        i. Equipment brochure/invoice/quote
        ii. Medical procedure/medical supplies – invoice/quote
        iii. Camp or seminar – literature with pricing
        iv. Home or vehicle modification quote
    f. Proof of household income - most recent income tax returns, etc. (mandatory upon request)

2. Mail application and required information to:
    Spina Bifida Association of Kentucky
    982 Eastern Pkwy., Ste. 18
    Louisville, KY 40217-1575

    Or

    Email your application to: sbak@sbak.org

3. SBAK staff may contact you if additional information is needed.
4. Application is presented to the Committee for review.
5. SBAK staff contacts family/individual with committee decision
6. If funds are approved, SBAK pays provider, school, camp etc. directly

APPLICATION

Financial Assistance Fund for Medical, Recreational and Independent Living Needs

Application Date _____

Name of individual with spina bifida _____ **DOB** _____

Parent or Guardian_____

Address _____

City _____ **State** _____ **Zip** _____

Telephone: Home: _____ **Cell:** _____

Email Address: _____

Preferred method of contact ☐ **Phone** ☐ **Email**

Are you active with SBAK ☐ **Yes** ☐ **No**

If yes, what programs or events have you attended?

How did you hear about the Financial Assistance Fund?

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

If this request is granted, how will it benefit you?

Medical Request (for medical expenses, equipment or therapy)

Please attach documents supporting the request as applicable

- 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:

Conference or Training Request (funds to attend a conference or training)

Please attach a brochure or description of the conference or training

Has SBAK assisted you with expenses for a conference or training in the past? ☐ Yes ☐ No

If Yes, when? _____

Please list amounts needed (fees, meals, rooms, etc)

Daily Living or Recreational Request (funds to enhance or support independent living or recreational activities)

Please attach brochures for recreational camps or training seminars. Include cost quotes or invoices and attach pictures if available.

Please describe the request

IF YOUR REQUEST FOR ASSISTANCE IS DENIED, DO YOU HAVE ANOTHER SOURCE TO HELP WITH THIS REQUEST? ☐ YES ☐ NO

Explain:

Household Income (additional proof may be requested)
Number of Members in Household Adults (age 18 & over) _____ Children (17 & under)_____

Monthly Income

$ _____ Wages/Pay, Head of Household

$ _____ Wages/Pay, Other Household Members

$ _____ Unemployment or Worker's Compensation

$ _____ Disability Assistance

$ _____ Social Security

$ _____ Child Support

Monthly Expenses

$_____ Mortgage/Rent

$ _____ Transportation (car payment, gas, etc)

$_____ Utilities

$ _____ Insurance

$ _____ Food

$ _____ Medications

Other 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 Applicant _____ Date _____

*By signing this form electronically you are agreeing to the terms and conditions stated herein

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.