



## Contribution Guidelines for Recreational Programs

The Spina Bifida Coalition of Cincinnati is an organization working to enhance the lives of all affected with Spina Bifida through education, parental support, social networking, advocacy and public awareness. We are parents, professional, and adults with Spina Bifida collaborating to offer programs, resources and encouragement to families living in the tri-state region. We believe individuals with Spina Bifida can achieve their maximum potential with support, information and accommodations.

To this end, it is the policy of the Spina Bifida Coalition of Cincinnati, Inc. to assist community programs in offering inclusive recreational activities for individuals with Spina Bifida that can further enrich their lives. To ensure these opportunities are available for recreation in the community, we, as an association, may provide up to \$75.00 for each individual with Spina Bifida participating in a group activity to be used by the organization for the purchase of equipment, facility rental or administrative fees. We may also give referrals to other organizations that can be applied to for financial assistance.

Please fill out the attached application form and return to:

The Spina Bifida Coalition of Cincinnati,  
644 Linn Street, Suite 635  
Cincinnati, OH 45203

The Spina Bifida Coalition of Cincinnati Scholarship Chair will review your application and get back to you within 2 weeks of your acceptance. If you have any questions, please feel free to call us at 513-923-1378 or contact us by e-mail at [sbccincy@sbccincy.org](mailto:sbccincy@sbccincy.org). These funds are limited and are available on a first come, first served basis per quarter. Applications will be taken for each quarter beginning on January 1, April 1, July 1 and October 1 of each calendar year.

For more information, call 513-923-1378 or e-mail [sbccincy@sbccincy.org](mailto:sbccincy@sbccincy.org).



## Application for Financial Assistance to Organization

What is the full legal name of your program / organization, mailing address and name of the contact person \_\_\_\_\_

\_\_\_\_\_

Federal tax ID #, if applicable \_\_\_\_\_

Phone number / fax number / email address for the organization

\_\_\_\_\_

Briefly describe the goals and mission of this program and / or organization \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where is this activity being held \_\_\_\_\_

What is the cost for each person to participate in the described program / activity \_\_\_\_\_

How often will this program / activity occur \_\_\_\_\_

Number of current participants in your program who have Spina Bifida (or last year, if applying prior to registration) \_\_\_\_\_

Contact information for individuals with Spina Bifida or their families who participate in this program / activity, including city and state (continue on back of page, if necessary)

\_\_\_\_\_

\_\_\_\_\_

How will funding be applied \_\_\_\_\_

What other financial support do you receive for this program / activity \_\_\_\_\_

\_\_\_\_\_