SPINA BIFIDA ASSOCIATION
OF INDIANA

To promote the prevention of Spina Bifida and to enhance the lives of all affected

2019 SBAIN ASSISTANCE APPLICATION

I AM APPLYING FOR:

_______MEDICAL	_______CONFERENCE
_______CAMP	_______COLLEGE

- ***Applicant may request up to $500 total per calendar year.*** *Each family member is eligible for up to $500 of reimbursement split among all of the funds or totally coming out of one fund. For example, if you request $500 for medical reimbursement, you will not be eligible for any additional reimbursements in that calendar year from any other fund. However, you can split them among funds as you wish.* ***When the applicant is making his or her first application to SBAIN for funds, a letter from a physician confirming that the patient has Spina Bifida is required.***

NOTE: Reimbursements will be subject to review and available SBAIN funds.

<u>Medical Guidelines</u>:

- Applicant must have spina bifida.
- Applicant must provide all requested information. Reimbursement requests **MUST** be submitted with this application form for proper tracking and documentation.
- Funds may be used for, but not limited to: durable medical equipment, Orthotic braces, catheters, incontinence products, Ritalin or other prescription drugs not covered by health care plans. Reimbursement items are subject to approval by the SBAIN Board of Directors.
- Receipt(s) for all items must be submitted with the application along with proof of non-coverage by the family's health care plan. (IE: EOB from insurance plan)
- Current year's applications must be received prior to January 31, 2020

We encourage you to file applications earlier in the year.

Please be aware that application approval may take up to 60 days depending upon number of applicants and the time of year applications are received into the SBAIN office. (Approval may take longer if applications are received at the end of year and/or beginning of next year.)

<u>Camp Guidelines</u>: THIS APPLICATION MUST BE SUBMITTED PRIOR TO ATTENDING

- Applicant must have spina bifida.
- Applicant must provide all requested information.
- Eligible camps include: A. Camps specifically designed for people with disabilities: B. Special events upon board approval.
- For those attending Camp Riley, and have applied for early registration, disbursements will go directly to the Riley Children's Foundation.
- Reimbursements to families will only occur after the event has been attended with submission of proof of attendance and payment. However, SBAIN MUST have received an initial application prior to attending the camp and approval for the scholarship was given by the board.

Conference Guidelines: THIS APPLICATION MUST BE SUBMITTED PRIOR TO ATTENDING

- Consider other opportunities for payment such as for those on waiver programs, please check with caseworker prior to filling out and signing the application.
- Applicant must have Spina Bifida or be a parent of a child with Spina Bifida.
- Eligible conferences related to disabilities or Spina Bifida.
- All financial reimbursement will occur after the conference. You are responsible for paying all fees up front and submitting valid receipts of all expenses.
- Expenses for travel including lodging, air fare, gas, rental vehicles, and food are eligible for reimbursement. Alcoholic beverages are not reimbursable.

College Guidelines:

- Applicant must have Spina Bifida.
- Applicant must be enrolled in or accepted by a college, junior college, approved trade, vocational, or business school.
- Applicant must provide receipts of college related expenses such as tuition and/or books.

Return all applications to: SBAIN P.O. Box 19814 Indianapolis, IN 46219-0814
Or scan in an email to sbainoffice@sbain.org

APPLICANT INFORMATION		
Name of Individual with Spina Bifida:		
Name of Parent or Guardian (if a minor):		
Current address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	
Email Address:		Date of birth:
PURPOSE OF REQUEST		
REQUEST AMOUNT *(REQUEST CANNOT EXCEED $500.00 PER CALENDAR YEAR)*		
	AMOUNT APPROVED BY SBAIN BOARD:	
	DATE APPROVED BY SBAIN BOARD:	
SIGNATURES		
BY SIGNING BELOW I CERTIFY THAT ALL THE INFORMATION PROVIDED IS TRUE AND CORRECT. I CERTIFY THAT THE ITEMS LISTED ARE FOR THE BENEFIT OF THE APPLICANT. IF ANY INFORMATION IS INTENTIONALLY FALSE, I AGREE TO REIMBURSE SBAIN ALL COSTS, LEGAL AND OTHERWISE, TO RECOVER THE DISBURSED FUNDS.		
Signature of applicant (*or parent or guardian if a applicant is a minor*):		Date: