



## SPINA BIFIDA ASSOCIATION OF INDIANA

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

# MEDICAL FINANCIAL ASSISTANCE APPLICATION

### General Guidelines:

- ***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.***
- *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.)*

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

### Medical Guidelines:

- Applicant must have spina bifida confirmed by a physician's letter specifying the diagnosis.
- Applicant must provide copy of insurance card front and back.
- Applicant must provide all requested information. Reimbursement requests **MUST** be submitted with this application form for proper tracking and documentation.
- Applicant must be a member of SBAIN. Membership is free. If not a member, application may be completed by clicking on "Join" on the sbain.org website home page.
- 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 plan. Reimbursement items are subject to approval by the SBAIN Board of Directors. Funds may be denied if member applicant is not utilizing insurance plan's list of preferred providers.
- Examples of items not covered: gas, car repairs or maintenance, moving expenses, home modifications, tutoring, or treatments not recommended through the SBA Healthcare Guidelines.
- Receipt(s) for all items must be from the current year and 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 of the following year. For instance, **2020** receipts may be submitted with an application until January 31, **2021**.

**We encourage you to file applications earlier in the year.**

<i>For office use only</i>	
<b>Membership list</b>	
<b>Copied</b>	
<b>Amount approved</b>	
<b>Date approved</b>	



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**Return all applications to:** SBAIN P.O. Box 19814 Indianapolis, IN 46219-0814  
Or scan in an email to [sbainoffice@sbain.org](mailto:sbainoffice@sbain.org) (preferred)

<b>APPLICANT INFORMATION</b>		
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:
Insurance Provider:		
Insurance Phone:		
<b>PURPOSE OF REQUEST</b>		
<b>REQUEST AMOUNT (REQUEST CANNOT EXCEED \$500 PER CALENDAR YEAR)</b>		
<b>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.</b>		
Signature of applicant (or parent or guardian if a applicant is a minor):		Date: