



**SPINA BIFIDA ASSOCIATION
OF DELAWARE VALLEY**

P.O. BOX 859, WORCESTER, PA 19490
800-223-0222 WWW.SBADV.ORG

FINANCIAL ASSISTANCE CHECKLIST

<p style="text-align: center;">GENERAL INSTRUCTIONS</p> <ol style="list-style-type: none"> 1. Fill out the General Application on page 2. 2. Provide all the information requested for the application type 3. Sign the certification at the end of the application form. 4. Make a copy for your records. 5. Mail to SBADV office, P.O. Box 859, Worcester, PA 19490 ATTN: Fund Name 	<p style="text-align: center;">INCONTINENCE FUND</p> <ol style="list-style-type: none"> 1. Your health insurance must be approached first. 2. The following documentation must be included with your request: <ul style="list-style-type: none"> <input type="checkbox"/> Completed Application <input type="checkbox"/> Original Receipts <input type="checkbox"/> Insurance Company Benefits Statement (either denial, or amount paid). <input type="checkbox"/> Send form to SBADV office, ATTN: Incontinence Fund
<p style="text-align: center;">DIRECT PATIENT AID</p> <ol style="list-style-type: none"> 1. Your health insurance must be approached first. 2. The following documentation must be included with your request: <ul style="list-style-type: none"> <input type="checkbox"/> Completed Application <input type="checkbox"/> Original Bills/Receipts (must show name of patient/member. I.e., prescription receipt must show name of medicine and who it was prescribed for). <input type="checkbox"/> Insurance company benefits statement (either denial or amount paid). <input type="checkbox"/> Must include proof of payment. (Cancelled check or receipt) <input type="checkbox"/> Send form to SBADV office, ATTN: Direct Patient Aid 	<p style="text-align: center;">POST SECONDARY EDUCATION FUND</p> <ol style="list-style-type: none"> 1. The following documentation must be included with your request: <ul style="list-style-type: none"> <input type="checkbox"/> Completed Application <input type="checkbox"/> A brief essay detailing the name of the school you plan to attend, the name of the program you plan to take, a list of proposed courses, your academic activity to date (secondary and post-secondary), employment history, and your short term and long term goals. <input type="checkbox"/> Proof of payment for educational expenses <input type="checkbox"/> Documentation of student being in good standing at an academic institution <input type="checkbox"/> Send form to SBADV office, ATTN: Post Secondary Ed.
<p style="text-align: center;">DRIVER'S EDUCATION</p> <ol style="list-style-type: none"> 1. The following documentation must be included with your request: <ul style="list-style-type: none"> <input type="checkbox"/> Completed Application <input type="checkbox"/> Original billing receipts from the driver education school <input type="checkbox"/> A letter from the Office of Vocational Rehabilitation stating that the cost will not be reimbursed. <input type="checkbox"/> Send form to SBADV office, ATTN: Driver's Education 	<p style="text-align: center;">EQUIPMENT FUND</p> <ol style="list-style-type: none"> 1. Your health insurance must be approached first. 2. The following documentation must be included with your request: <ul style="list-style-type: none"> <input type="checkbox"/> Completed Application <input type="checkbox"/> Original Bill/Receipts <input type="checkbox"/> Insurance company benefits statement (either denial or amount paid). <input type="checkbox"/> Send form to SBADV office, ATTN: Equipment Fund

Discretionary Fund – For those participating or competing in events at a National Level.



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FINANCIAL ASSISTANCE APPLICATION

INCONTINENCE FUND DIRECT PATIENT AID EQUIPMENT FUND DRIVER'S EDUCATION
 POST-SECONDARY EDUCATION FUND DISCRETIONARY FUND

Applicant's Name _____ Date of Birth _____

Street Address _____

City State, Zip _____

Phone _____ Email _____

Parent's Names (if applicant is a minor) _____

Amount Requested: _____ Check payable to: _____

For most funds, health insurance must be approached first. Please complete the following information about your health plan coverage.

Name of Carrier _____ Group/Plan Number _____

Address of Carrier _____

Checks are distributed on a quarterly basis. All requests are due on March 31st, June 30th, September 30th, and December 31st. All submissions must be made no later than September 30th for claims occurring during the previous calendar year. ALL DECISIONS OF THE BOARD OF DIRECTORS ARE FINAL.

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 SBADV ALL COSTS, LEGAL AND OTHERWISE, TO RECOVER THE DISBURSED FUNDS.

SIGNATURE _____ DATE: _____

For Office Use Only: Approved by: _____ Amount _____ Date _____