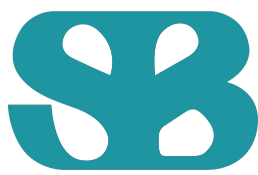


SPINA BIFIDA ASSOCIATION OF THE DELAWARE VALLEY

6935 Airport Hwy Lane
Office 1
Pennsauken, NJ 08109
1-800-223-0222

FINANCIAL ASSISTANCE CHECKLIST

GENERAL INSTRUCTIONS

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, 465 Colfax Road Havertown, PA 19083-5835 ATTN: Fund Name**

INCONTINENCE FUND

1. Your health insurance must be approached first.

2. The following documentation must be included with your request:
- Completed Application
- Original Receipts
- Insurance Company Benefits Statement (either denial, or amount paid).
- Send form to SBADV office, ATTN: Incontinence Fund

DIRECT PATIENT AID

1. Your health insurance must be approached first.

2. The following documentation must be included with your request:
- Completed Application
- Original Bills/Receipts (must show name of patient/member. I.e., prescription receipt must show name of medicine and who it was prescribed for).
- Insurance company benefits statement (either denial or amount paid).
- Must include proof of payment. (Cancelled check or receipt)
- Send form to SBADV office, ATTN: Direct Patient Aid

POST SECONDARY EDUCATION FUND

1. The following documentation must be included with your request:
- Completed Application
- 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.
- Proof of payment for educational expenses
- Documentation of student being in good standing at an academic institution
- Send form to SBADV office, ATTN: Post Secondary Ed.

DRIVER'S EDUCATION

1. The following documentation must be included with your request:

- Completed Application
- Original billing receipts from the driver education school
- A letter from the Office of Vocational Rehabilitation
- stating that the cost will not be reimbursed.
- Send form to SBADV office, ATTN: Driver's Education

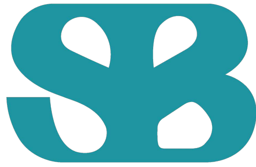
EQUIPMENT FUND

1. Your health insurance must be approached first.

2. The following documentation must be included with your request:

- Completed Application
- Original Bill/Receipts
- Insurance company benefits statement (either denial or
- amount paid).
- 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 March 15th 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____________