



Spina Bifida Association of Connecticut

Please Print

Today's Date: \_\_\_\_\_

**Application for MEDICAL Assistance**

Name of person for whom aid is being requested: \_\_\_\_\_

Name of Parent or Guardian (if under 18): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail address \_\_\_\_\_

Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Night Phone: (\_\_\_\_\_) \_\_\_\_\_

Are you currently receiving any additional financial assistance for these expenses?:  Yes  No

If Yes, Please describe this assistance: \_\_\_\_\_

Prior SBAC Cash awards since last October: \$ \_\_\_\_\_

All of the information contained on this form is true and correct to the best of my knowledge. I hereby give the SBAC permission to verify any of this information. I understand that although a maximum ANNUAL distribution from the SBAC is pre-determined, this amount will only be awarded according to the SBAC allocation policy.

Signed, \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**This application is for:**

- Medical Expenses - office visits, procedures, medications (must be spina bifida related)
- Durable equipment, disposable supplies
- Mobility aids (wheelchair, crutches, walker)

Vendor/Hospital: \_\_\_\_\_  Receipt attached or  Bill or Invoice for unpaid amount attached

The Device/Procedure was prescribed by: \_\_\_\_\_

- Prescription attached or Doctor's signed letter attached.
- Insurance refusal attached.

**Rules for Application**

1. Application must be for a person with spina bifida. A physician statement of disability is required, including the physician's address and phone number.
2. Applicant must reside in the SBAC service area, the State of Connecticut.
3. We reimburse out of pocket expenses only. We will NOT duplicate any expense already paid for by an insurance company or state, federal or private agencies.
4. All applications must be accompanied by documentation as requested on application.
5. Applications for orthopedic equipment, prescriptions for medications, and corrective treatments all require a prescription or a doctor's signed letter.
6. Applications for MEDICAL allocations must **be postmarked by March 1<sup>st</sup> or September 1<sup>st</sup>**.
7. Checks will be made payable to the provider, unless a paid invoice is provided.
8. All expenditures must have been incurred within 12 months of the application deadline.
9. Awards are paid at a level of 25% of unpaid or out-of-pocket amount, with a Maximum payout of \$500 per calendar year.