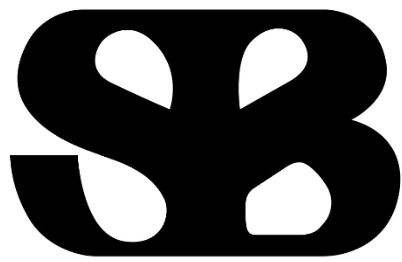

SPINA BIFIDA
ASSOCIATION
OF KENTUCKY

Financial Assistance Fund Application

General Guidelines for Financial Assistance

- Monies are given only for the direct benefit of an individual affected by Spina Bifida
- Applicants need to show that paying for this themselves would be a hardship.
- A designated committee will determine if there is a vital need and true financial hardship
- Monies are never paid to an individual, only directly to the provider/supplier, camp, school, etc.
- Documentation must be provided by the medical professional, equipment company, conference or seminar, camp etc., to whom the payment will be made
- Assistance cannot be provided on an ongoing basis.
- No medications are covered.
- The applicant must reside in Kentucky or the Southern Indiana service area.
- All monies granted must have a purpose that supports the Spina Bifida Association of Kentucky's mission.
- All monies granted will be audited by an independent CPA in accordance with generally accepted auditing standards

Categories for Financial Assistance

- Medical & therapeutic expenses not covered by insurance
- Durable medical equipment (wheelchairs, standers, walkers, crutches, braces, etc)
- Home modifications for accessibility
- Recreational equipment: hand-cycles, sports-chairs, etc.
- Funds to attend educational/medical conferences and/or seminars
- Fees to attend children's camps
- Transition to Independence Specialized Programs
- Vehicle modification
- Emergency Assistance: available on a one-time basis to help with utilities, rent, etc., when the financial hardship is the direct result of Spina Bifida

Due to budgetary limitations large expenses cannot be approved, but partial assistance may be possible.

Application Process

1. Complete the application.
2. Email or Mail application and required information to:

   sbak@sbak.org   Spina Bifida Association of Kentucky
   982 Eastern Pkwy Ste18
   Louisville, KY 40217-1575

3. SBAK staff will contact you if additional information is needed.
4. All identifying information is redacted and the application is presented to the Committee for review
5. You will be notified when a decision has been made. If assistance is approved, arrangements for payment directly to the provider will be made.

SBAK FINANCIAL ASSISTANCE APPLICATION

Application Date

Name of individual with Spina Bifida
Date of Birth

Person Completing This Application

Relationship to Person with Spina Bifida

Address
City **County** **State** **Zip Code**

Telephone **Home** **Cell**

Email address
Preferred Contact: **Phone** **Email**

Are you active with SBAK? **Yes** **No**
If yes, what programs or events have you attended?

How did you hear about the Financial Assistance Fund?

Have you been helped by the Financial Assistance Fund in the past? **Yes** **No**
If Yes, please describe how and when you were helped.

Please describe how the assistance you are requesting will increase function and benefit in the community and/or home as it pertains to Spina Bifida and how it will benefit you?

TYPE OF REQUEST:

Medical/Therapy/Equipment
Conference/Training
Daily Living/Recreational
Emergency Assistance

Please attach any documentation supporting this request such as:

- **Medical prescription or orders**
- **Cost quote for the item/service from the provider**
- **Insurance estimate or denial**
- **Photos, brochures**

Please describe the request and all costs associated:

If your request is denied, do you have another source of funding to help? Yes No
Explain:

Monthly Household Income (additional proof may be requested)

- $ Wages/Pay Head of Household
- $ Wages/Pay All Others in Household
- $ Disability Assistance
- $ Unemployment or Worker's Compensation
- $ Social Security
- $ Child Support
- $ Other (SNAP, WIC, etc)

Total Monthly Income $ **NET**

Number of Household Members **Adults** **Children (17 and under)**

Monthly Household Expenses

- $ Mortgage/Rent
- $ Transportation (car payment, gas, insurance, etc)
- $ Utilities
- $ Insurance (medical, homeowner's)
- $ Food
- $ Medications
- $ Other Expenses (explain below)

Total Monthly Expenses $

Other information that you wish to share with the committee

Funds available are limited. I understand that the decision of the committee is final.

Signature of Applicant **Date**

***By signing this form electronically, you are agreeing to the terms and conditions stated herein**

Information provided on this application form is confidential. The written permission of the adult applicant or the parent/guardian of a child applicant is required for information to be shared with another agency, professional or provider. Applications will be retained by SBAK for two years.