

## 2010 EMERGENCY ASSISTANCE APPLICATION

Name of Individual \_\_\_\_\_ Date of birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ (business) \_\_\_\_\_ (cell) \_\_\_\_\_  
Best time to call \_\_\_\_\_ Email \_\_\_\_\_

Request for medical expenses, equipment, therapy or urological supplies and continence products for individuals over the age of 3

Please attach the following supporting documents: Doctor's or Physical Therapist's prescription  
Cost of the item/service  
Explanation of insurance benefits paid (or denied)

**Describe the item or service:**

Vendor \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**If this request is granted, how will it benefit you?**

**Do you have another source to help with this expense if this request is denied?**

\_\_\_\_ No \_\_\_\_ Yes If yes, please explain

**Family Income**

\$ \_\_\_\_\_ Yearly household income (wages)  
\$ \_\_\_\_\_ Unemployment  
\$ \_\_\_\_\_ Worker's Compensation  
\$ \_\_\_\_\_ Disability Assistance  
\$ \_\_\_\_\_ Social Security  
\$ \_\_\_\_\_ Child Support  
\$ \_\_\_\_\_ TOTAL HOUSEHOLD YEARLY INCOME

Number of family members living in the household \_\_\_\_ Adults \_\_\_\_ Children

**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 individual or parent

\_\_\_\_\_  
Date

## **EMERGENCY ASSISTANCE FUND GUIDELINES**

### Eligible categories for Emergency Assistance

- Medical expenses
- Equipment
- Therapy
- Urological supplies
- Continence products for individuals over the age of 3

### **GENERAL GUIDELINES**

- Through this application process, a designated committee will determine if there is a vital need and true financial hardship.
- Money given is for the direct benefit of the individual affected by Spina Bifida.
- Applicant needs to prove that he or she (or parent (s)) is unable to pay for this request.
- Money is not paid to an individual. Money will be paid directly to vendor/supplier.
- Required documentation must be from medical professional, equipment company, etc.
- Money is given for a one-time event/situation.
- No medication is covered with the exception of urological medications.
- All money granted will be in accordance with generally accepted accounting principles (GAAP) and will be audited in accordance with generally accepted auditing standards (GAAS) by an independent CPA.

### **APPLICATION PROCEDURE**

1. Fill out application completely.
2. Include necessary documentation:
  - a. Letter from medical professional stating need
  - b. Proof of cost – invoice or quote
  - c. Proof of household income
3. Mail application and attached information to:  
Spina Bifida Association of Illinois  
8765 W. Higgins Rd., Suite 403  
Chicago, IL 60631
4. SBAIL staff may contact you if additional information is needed.
5. Application is presented to the Committee.
6. Committee reviews.
7. Designated staff contacts family or individual.
8. If funds are approved, SBAIL will pay provider directly.