

2011 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.