To support, empower, and connect all those impacted by Spina Bifida in Indiana

MEDICAL FINANCIAL ASSISTANCE APPLICATION

General Guidelines:

- ***Applicant may request up to $1000 total per calendar year.*** *Each family member is eligible for up to $1000 of reimbursement per calendar year. (Camp Fund Requests are processed separately.)* ***When the applicant is making his or her first application to SBIND for funds, a letter from a physician confirming that the patient has Spina Bifida is required.***
- *Please be aware that application approval may take up to* ***60 days*** *depending upon number of applicants and the time of year applications are received into the SBIND office. (Approval may take longer if applications are received at the end of year and/or beginning of next year.)*

NOTE: Reimbursements will be subject to review and available SBIND funds.

Medical Guidelines:

- Applicant must have Spina Bifida confirmed by a physician's letter specifying the diagnosis.
- Applicant must provide all requested information and receipts. Reimbursement requests **MUST** be submitted with this application form for proper tracking and documentation.
- Funds may be used for, but not limited to: durable medical equipment, Orthotic braces, catheters, incontinence products, Ritalin or other prescription drugs not covered by health care plan. Reimbursement items are subject to approval by the SBIND Board of Directors. Funds may be denied if member applicant is not utilizing insurance plan's list of preferred providers.
- Examples of items not covered: gas, car repairs or maintenance, moving expenses, home modifications, tutoring, or treatments not recommended through the SBA Healthcare Guidelines.
- Receipt(s) for all items must be from the current year and submitted with the application along with proof of non-coverage by the family's health care plan. (IE: EOB from insurance plan)
- Current year's applications must be received prior to January 31 of the following year.

We encourage you to file applications earlier in the year.

For office use only	
Membership list	
Copied	
Amount approved	
Date approved	

Spina Bifida INDIANA

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MEDICAL FINANCIAL ASSISTANCE APPLICATION

Return all applications to: Scan in an email to sbindoffice@sbind.org (preferred)
Or mail to: SBIND PO Box 40558 Indianapolis, IN 46240

APPLICANT INFORMATION		
Name of Individual with Spina Bifida:		
Name of Parent or Guardian (if a minor):		
Current address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	
Email Address:		Date of birth:
Insurance Provider:		
PURPOSE OF REQUEST		
REQUEST AMOUNT *(REQUEST CANNOT EXCEED $1000 PER CALENDAR YEAR)*		
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 SBIND ALL COSTS, LEGAL AND OTHERWISE, TO RECOVER THE DISBURSED FUNDS.		
Signature of applicant (*or parent or guardian if an applicant is a minor*):		Date: