Only expenses related to Spina Bifida for the year 2018 are eligible. Complete applications must be postmarked by March 31, 2019. Funds will be allocated by June 1, 2019. (DEPENDS ON WHEN BOARD MEETS)

GUIDELINES

* The fund covers medical expenses related to Spina Bifida that have not been paid nor are eligible to be paid for by insurance, Medicaid or other funding sources.
* Copies of itemized receipts and insurance allowance and/or denial statements must accompany the completed application.
* Please email or call Donna Willome after you mail your application so that I can be on the lookout for it. [dwillome@rochester.rr.com](mailto:dwillome@rochester.rr.com) or (585)233-2693.
* All information is considered confidential and will be sealed and stored after funding decisions are made.
* Grants are subject to availability of funds.

EXAMPLES OF ITEMS COVERED

* Orthopedic equipment co-pays
* Medication, lab co-pays
* Urinary and bowel control supplies (diapers for children over age 2) including gloves, catheters etc.
* Home and vehicle modifications
* Adapted recreation equipment
* Other expenses not covered by insurance or other funding sources.

# **APPLICATION**

# **Name of person with Spina Bifida: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_**

Parents’ names (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does individual with Spina Bifida receive Medicaid? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

For the 2018 calendar year, the following purchases have been made for the person with Spina Bifida.

ITEM DATE COST SUBMITTED

to insurance (Y or N)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please submit all claims to your insurance company BEFORE submitting your request. Include COPIES of receipts, insurance allowances and denials.

I certify that the above information is true to the best of my knowledge and that I am submitting expenses that qualify under the guidelines of this program. I have not been nor do I expect to be reimbursed for these expenses by any other group or agency.

Individual or parent signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail with copies of documents to:

GRSBA Non-Reimbursable Medical Equipment Fund

100 City View Drive, Rochester, New York 14625

For further assistance call Donna Willome: (585)233-2693