SPINA BIFIDA OF WESTERN NEW YORK, INC.

137 Warner Avenue, North Tonawanda, New York 14120
Telephone: (716) 446-5595

BRACE AND EQUIPMENT FUND APPLICATION

Date of Application _____

Name of Person (with SB, hydrocephalus or related neural tube defect) Requesting Aid:

_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Check One: Child _____ Adult _____ Date of Birth: _____

If child, name of parent requesting grant: _____

How long have you been a dues-paying member of the SBWNY? _____

Which SBWNY Committee or function have you been assisting with? _____

Amount of aid requested? _____ (maximum of $400 per calendar year)

Medical or related procedure(s):_____

Dates of procedure(s): _____

Orthopedic equipment, supplies, etc: _____

Amount covered by Insurance, State Aid, Medicaid or Other Sources: _____

Fund eligibility and the amount awarded are solely at the discretion of the fund's administrative committee. The SBWNY Board of Directors reserves the right to discontinue this fund at any time or if all funds have been depleted.

Please refer to the reverse side of this application for the "Brace and Equipment Fund Rules of Operation."

Send this completed application with ***original*** receipts attached to one of the following Brace and Equipment Fund Administrative Committee members:

Primary: Pam Morris
137 Warner Avenue
N. Tonawanda, NY 14120

Alternate: Karen Savanyu
1709 Beaver Meadow Road
Java Center, NY 14086

FOR SBWNY USE ONLY: Current dues paid? Circle YES or NO Date paid: _____
Approved by: _____ Date: _____ Amount: $_____
Paid by: _____ Date: _____ Check # _____

BRACE AND EQUIPMENT FUND RULES OF OPERATION

Effective January 1, 2008

1. Spina Bifida of Western New York, Inc. (SBWNY) Board of Directors reserves the right to amend these rules and to discontinue this fund if/when funds have been depleted.

2. All fund recipients are encouraged to be current dues paying members of the SBWNY.

3. All fund recipients are encouraged to volunteer on a committee or assist with a SBWNY function or fundraiser. Fund recipients will be added to a volunteer database and they may be called upon occasionally to assist with functions and/or fundraisers.

4. All fund recipients must reside in SBWNY's service area, which includes only the following New York counties: Erie, Niagara, Allegany, Orleans, Cattaraugus, Chautauqua, Wyoming, and Genesee.

5. ***Original*** receipts must accompany all fund requests.

6. Applications for reimbursement of prior year expenditures must be submitted no later than March 31. No prior year applications will be accepted after that date.

7. Brace and Equipment Fund applications may be made by individuals with spina bifida and/or hydrocephalus to help defray costs related to **orthopedic equipment (walkers, crutches, shoes, RGO's and other bracing equipment), incontinence supplies (diapers for ages 3 years and up), glasses, adaptive equipment (ramps, lifts, wheelchairs and repairs, scooters, etc.), adapted sports equipment (sledges, sports wheelchairs, etc.) and assistive technology to compensate for physical and/or learning disabilities related to spina bifida, hydrocephalus and related neural tube defects.**

8. Funds are available up to a yearly maximum of $400.00 per person, based on availability of funds. Grant eligibility and amount are solely at the discretion of the fund's administrative committee. Funds are not guaranteed. In the event that an application is denied, the applicant will be notified in writing.

9. An application, along with ***original*** receipts must be submitted with each request. The SBWNY treasurer will issue payment within 30 days of receipt of the administrative committee's approval and depending upon availability of funds.

10. Applications may be obtained from the following Brace and Equipment Fund Administrative Committee members:

Primary: Pam Morris
137 Warner Avenue
N. Tonawanda, NY 14120
Phone: (716) 694-8567

Alternate: Karen Savanyu
1709 Beaver Meadow Road
Java Center, NY 14082
Phone: (585) 457-9867

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