SPINA BIFIDA OF WESTERN NEW YORK, INC.

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

RESPITE REIMBURSEMENT 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 $300 per calendar year)

For consideration, please briefly describe the activity you (the caregiver) will pursue while respite is being used:

_____

_____

_____

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 third page of this application for the "Respite Reimbursement Fund Rules of Operation."

Send this completed application with *original* signatures to one of the following Respite Reimbursement Fund Administrative Committee members:

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

Alternate: Karen Savanyu
1709 Beaver Meadow Road
Java Center, NY 14082

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

SBWNY RESPITE SERVICE VERIFICATION FORM

PARTICIPANT: Name _____
(name of individual with spina bifida and/or hydrocephalus)
Date of Birth: _____

PARENT/GUARDIAN: Name _____
Address _____
_____ ZIP _____
Telephone: _____

RESPITE WORKER: Name _____
Address _____
_____ ZIP _____
Telephone: _____

Month/Day/Year	Time In	Time Out	No. of Hours	Respite Worker's Full Signature

Total Number of Hours: _____ Hourly Rate: $_____

Hourly Rate multiplied by Total Number of Hours equals reimbursement requested: $_____

Signature of Parent/Guardian: _____
Date: _____

Note: This form will be returned to you unpaid unless **ALL** categories are completed in full. A completed application consists of the Application Form along with this form and original signatures.

RESPITE REIMBURSEMENT 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* signatures 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. The Respite Reimbursement Fund was created to assist with dependent care for persons with spina bifida and/or hydrocephalus over 13 years of age. The purpose of the Fund is to give caregivers a respite for the purpose of vacation or leisure time. Normal child or dependent care costs, such as day care for working parents, will not be considered for reimbursement. Extra expenses incurred due to the extent of disability may be considered for reimbursement. Applications may be made by an immediate family member/caregiver of an individual with spina bifida and/or hydrocephalus who is not able to stay home alone. Respite service costs must be reasonable based upon the needs of the individual and established rates for similar services. **As a guideline**, respite services should be in the range of **$5.00 to $6.00 per hour and no more than $60 for a 24-hour period.** SBWNY reserves the right to contact respite workers directly to verify hours worked and payment received.

8. Funds are available up to a yearly maximum of $300.00 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 a completed SBWNY Respite Service Verification Form with *original* signatures, 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.

Applications may be obtained from and should be returned to one of the following Respite Reimbursement 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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