ISBA

illinois spina bifida association

2017 EQUIPMENT FUND APPLICATION

Name of Individual with SB ____ Date of birth_____________
Parent or Guardian Name (if individual w/SB is younger than 18, or when parent/guardian is requesting reimbursement): ____

Address ____City ____________ State_________ Zip_______
Telephone (home)__________________ (cell)____
Best time to call ____________________ Email____

Families are invited to request up to $250 toward out of pocket costs for orthotic or other mobility equipment. To qualify, the equipment must be utilized by an Illinois resident with spina bifida. The 2017 ISBA Equipment Fund is made possible by generous gifts from "A Helping Hand" and Kiwanis Clubs. Equipment funds will generally be available on a first come, first served basis, but priority consideration will be given to those who have not received other financial assistance from ISBA in the past 12 months. Questions? Contact us: 773-444-0305, info@i-sba.org.

Awarded funds will either (a) be paid directly to a vendor with whom the applicant has an outstanding balance of less than $1,000, or (b) directly to the applicant as reimbursement for expenses already paid in 2016-2017.

Equipment Type (pick one): ____ orthotic equipment ____ other mobility equipment

Equipment description: ____

Amount requested: ________ ($250 maximum)

This request is (pick one):

_____ to pay a vendor for a bill with an unpaid balance of less than $1,000
_____ to reimburse me for an expense that I have already paid in 2016-2017

Required documents:

1. Equipment supplier bill with an outstanding balance of less than $1,000
2. Or, for reimbursement requests: paid invoice with proof of payment (both sides of a cancelled check or credit card statement). The account name on the proof of payment must match the name of the individual signing this form if you are requesting reimbursement.

ISBA may request these documents after you submit your application:

3. Medical order describing the equipment needed
4. Documentation that the individual listed on the medical order has spina bifida, if not already included on the medical order

ISBA will destroy all documents containing medical information submitted by all applicants once the awards have been granted, regardless of whether your application is successful.

I consent to the disclosure of the submitted documentation, including medical information, for the limited purpose of ISBA considering this application. I certify that the information on this application is correct and true.

_______________________________________ ______________________________
Signature of individual with SB or parent / guardian Date

Mail the completed application and required documents to:

Illinois Spina Bifida Association, 2211 N. Oak Park Ave, Chicago, IL 60707