SPINA BIFIDA
OF JACKSONVILLE

MEDICAL REIMBURSEMENT ASSISTANCE APPLICATION
Maximum amount an individual with Spina Bifida can request in a calendar year is $300

To the Applicant: SBJ has established a Medical Reimbursement Assistance Fund to be dispersed to families living with spina bifida that need assistance with **uninsured** medical expenses (co-pays, medical supplies, adaptive equipment, and therapy directly related to caring for an individual with Spina Bifida.) Requests need to be submitted in writing. ***Financial assistance is limited and is offered on a first come, first served basis. If aid for the calendar year has been exhausted, no further aid will be granted until the next calendar year. This fund is established from dollars set aside for medical reimbursements.***

Eligibility Requirements:

- Applicant must have Spina Bifida or be a parent/caregiver of a child with Spina Bifida.
- Applicant must reside in North Florida or South Georgia.
- Application and required documentation must be received in its entirety.

Application Procedure:

1. Fill out application completely.
2. Please provide a copy of the receipts for the uninsured expenses being reimbursed or the uninsured invoice (or a valid prescription). Approved requests will be paid directly to creditor when applicable.
3. All expenses must be submitted in the year in which the expense incurred. Expenses occurring in December will be reviewed in January of the following year.
4. Applications will be reviewed on a monthly basis.
5. Mail applications and attached information to:

   Spina Bifida of Jacksonville
   807 Children's Way
   Jacksonville, FL 32207

6. The application will be presented to the SBJ Reimbursement Review Committee for review.
7. SBJ staff or board members may contact you if additional information is needed.
8. Designated SBJ staff will contact the family or individual upon approval or disapproval of the request. If approved, SBJ will discuss disbursement arrangements with the applicant.

This application does not cover requests for community awareness scholarships, camp/recreation program/special event, primary and secondary education support, and automobile modifications.

SBJ reserves the right to revise this policy annually in accordance with its changing financial position.

SPINA BIFIDA MEDICAL REIMBURSEMENT ASSISTANCE APPLICATION

Name of Individual with Spina Bifida:					
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:					
Purpose of Request (Please use additional sheet if necessary)					
AMOUNT REQUESTED:					
CHECK PAYABLE TO:					

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 FALSIFIED, I AGREE TO REIMBURSE SBJ ALL COSTS, LEGAL AND OTHERWISE, TO RECOVER THE DISBURSED FUNDS.

INFORMATION RELEASE

By filling out this application, I the applicant, by signing below, hereby grant The Spina Bifida Association of Jacksonville, Inc., the right to use my name, my picture submitted, my information, and my story described herein, without compensation, in electronic form (including the The Spina Bifida Association of Jacksonville, Inc., website) and/or in any Spina Bifida Association of Jacksonville, Inc, publication or written material. Applicant understands that The Spina Bifida Association of Jacksonville, Inc., will use my information, my submitted text, and my likeness only for promotional and/or educational purposes. I hereby agree to hold The Spina Bifida Association of Jacksonville, Inc., its licensees and affiliates harmless from any liability resulting from my statements and actions depicted or described in the information, text and graphic representations herein submitted.

Signature of applicant (or guardian if applicant is a minor):	Date:

Please send application & documentation to:

Spina Bifida of Jacksonville
807 Children's Way
Jacksonville, FL 32207

The exact amount to be disbursed will be at the discretion of the SBJ Board of Directors.

For more questions, call SBJ at 904-955-1032 or email jenna.price@spinabifidajax.org

For Staff Use Only:
Amount approved by SBJ Reimbursement Review Committee: Date approved by SBJ Reimbursement Review Committee:

[Rev. 07/2014]