GREATER ROCHESTER SPINA BIFIDA ASSOCIATION
Non-Reimbursable Medical Equipment Fund

The purpose of this program is to help offset expenses incurred by individuals with Spina Bifida or their families.
Only expenses related to Spina Bifida for the year **2014** are eligible. Complete applications must be postmarked by **May 31, 2015**. Funds will be allocated in **Summer 2015**.

GUIDELINES

- The fund covers only expenses **related to** Spina Bifida that have not been paid nor are eligible to be paid for out of state aid, insurance, Medicaid or other funding source.
- **Copies** of itemized receipts and insurance allowance and/or denial statements must accompany the completed application. You must submit receipts to your insurer **EACH YEAR** before submitting to us.
  - 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 or (585) 248-8973.
- 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 (crutches, braces, walkers, wheelchairs)
- Urinary and bowel control supplies (diapers for children over age 2)
- Gloves, lubricant, catheters
- Home and vehicle modifications
- Adapted recreation equipment
- Other expenses not covered by insurance or state agencies.

For Further Assistance Call: (585)248-8973

Revised: 2013

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Non-Reimbursable Medical Equipment Fund

Date: _____

Name of individual with Spina Bifida: _____

Parents' names (if applicable): _____

Address:

_____

Email _____**Phone:**_____

Health Insurance: _____

Does individual with Spina Bifida receive Medicaid? Yes _____ No _____

(If not, would you like information as to how to receive a Medicaid card or benefits? Yes _____ No _____

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

ITEM	DATE	COST	SUBMITTED to insurance (Y or N)

Please submit all claims to your insurance company **BEFORE** sending your request to us. 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: (585)248-8973

Revised: 2013