SPINA BIFIDA ASSOCIATION OF GREATER NEW ENGLAND

OFFICIAL POSTING
SBAGNE EMPOWERMENT BENEFIT 2023

Who Qualifies?

The Empowerment Benefit Grant is available to any member of the Spina Bifida Association of Greater New England ("*SBAGNE*") with spina bifida.

How much is the benefit?

- The amount, available number and qualifications for the calendar year are to be determined by ***SBAGNE's*** Board of Directors at the Annual Meeting of the prior year. The benefits will be determined by the Board of Directors based on the proposed budget for each calendar year and will be determined by the financial situation of ***SBAGNE.*** The benefits as determined by the Board of Directors shall be reflected in the Annual Empowerment Application revised for each calendar year.
- Because benefits are available to each youth or member with spina bifida, a family with more than one youth or member with spina bifida may apply for one grant for each member with spina bifida.
- ***SBAGNE*** reserves the right to revise this policy annually in accordance with its changing financial position.

For **Questions** email Jean Bertschmann at jbertschmann@sbagreaterne.org or call the office at 1-888-479-1900.

What Kinds of Expenses Qualify?

The benefit shall be used to reimburse for adaptive equipment; camp, adaptive sports, and recreation equipment; urological supplies for individuals over the age of 3; durable medical equipment and assistive technology.

When Should I Apply for Benefits?

Applications will be reviewed on an ongoing basis. **The 2023 program will be available to constituents until all funds are depleted**.

Distribution of Benefits:

Our goal is to allow each approved applicant to receive a benefit award. For 2023, each individual may apply for a maximum annual benefit award of $250. The award may be distributed in smaller amounts over the course of the year, if needed, up to a maximum of $250.

Emergency situations may be considered at the discretion of the ***SBAGNE*** Board of Directors. Please contact Jean Bertschmann for additional information.

How do I Apply for Benefits?

The applicant must do the following *or the application will not be approved*:

1. If you are not already a member of ***SBAGNE***, please follow this link to complete a membership form: https://sbagreaterne.org/news-events/become-a-member/

2. **There is no cost to become a SBAGNE member.**

3. Provide a statement of disability from physician, including address and telephone number of physician. If you have provided this information in previous years ***SBAGNE*** has it on file and it is not required. *A detailed medical history is not needed.*

4. Complete the application below.

5. Provide **proof of eligible expenses**:
    a. The applicant provides, *in advance of receipt of item or service,* a bill for an eligible expense that you want paid by your benefit. Once these receipts are received and approved, ***SBAGNE*** will write a check directly to the third party for the expense.
    b. If the applicant is applying for reimbursement for out of pocket allowable expenses, all receipts must be submitted with the application.

    SBAGNE prefers to pay third party vendors directly. The individual/family will be provided with a copy of the payment.

***SBAGNE* Action:**

A. Upon receipt, the Executive Director will:
    i. Review the application in accordance with the current guidelines;
    ii. If incomplete, ED will send out letter to the applicant and wait for further response to complete the application.
B. In accordance with an approved application, the Executive Director will:
    i. Send the direct payment to the provider with a copy of the correspondence to the person/parent.
    ii. If the application is denied, a letter with specific reasons must be mailed to the applicant within 5 working days. The applicant may resubmit a compliance application.
    iii. If reimbursement is sought, will send a check to the member.
C. ***SBAGNE*** does not exclude anyone from our New England area from applying for benefits unless the applicant does not have spina bifida.

SPINA BIFIDA ASSOCIATION OF GREATER NEW ENGLAND

Annual Empowerment Application 2023
Maximum total benefit for 2023 - $250

Applicant: _____ Date of Birth: _____

Parent/Guardian (if applicable): _____

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

Phone: _____ Email: _____

For the **OFFICIAL POSTING, log onto www.SBAGreaterNE.org** **For questions,** email Jean Bertschmann at JBertschmann@SBAGreaterNE.org or call our office at 1-888-479-1900.

Reimbursement for: _____
_____
_____
_____

Check payable to provider on attached invoice for $_____
Make check payable to:
Mailing Address:

Amount Requested with this application: $ _____

By signing below, I affirm the following:

- ***All information provided is true and accurate.***
- ***The above contact information is accurate.***
- ***I am a member of SBAGNE.***
- ***The beneficiary has spina bifida and documentation is provided from a physician. Distributions will not be made until documentation has been provided.*** Statement of disability from physician, including address and telephone number of physician. If you have provided this information in previous years SBAGNE has it on file and it is not required. A *detailed medical history is not needed.*
- ***The applicant resides in the SBAGNE service area.***
- ***If a portion of the application is deficient or if there is a question of residency, SBAGNE reserves the right to clarify and/or request additional information for the benefits***.

X_____ Date: _____
Applicant or Parent/Guardian Signature

Submit completed Application by mail, fax or email to:

Mail: ***SBAGNE***
219 East Main St, Suite 100B
Milford, MA 01757

Fax: 508-482-5301
Email: jbertschmann@SBAGreaterNE.org