



SPINA BIFIDA ASSOCIATION OF GREATER NEW ENGLAND

OFFICIAL POSTING SBAGNE EMPOWERMENT GRANT 2024

Who qualifies?

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

How much is the grant?

- The grant amount, available number, and criteria for each calendar year will be determined by the Board of Directors at the Annual Meeting of the prior year. The determination will be based on the proposed budget for each calendar year and the financial position of the organization. The grant amount and criteria, as determined by the Board of Directors, shall be reflected in the Annual Empowerment Grant Application revised for each calendar year.
- A family with more than one youth or adult with spina bifida may apply for one grant **for each member with spina bifida**.
- The maximum grant for 2024 is \$250/person with spina bifida.

What kinds of expenses qualify?

The benefit shall be used to pay for or reimburse payment for:

- adaptive equipment
- advocacy activity
- assistive technology
- durable medical equipment or supplies
- educational activity
- empowerment activity
- recreation activity and/or equipment
- social activity
- urological supplies for individuals over the age of 3

When should I apply?

Applications will be reviewed on an ongoing basis. The 2024 program will be available to all eligible SBAGNE members until all funds are depleted.

Distribution of grant awards:

Our goal is to allow each approved applicant to receive a grant award. For 2024, each individual may apply for a **maximum** annual grant award of \$250. The grant award **may be distributed in smaller amounts over the course of the year**, if needed, up to a maximum of \$250.

How do I apply for a grant?

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

1. If you are not already a member of SBAGNE, we request that you complete a membership form. There is no cost to become a member of SBAGNE.

Please follow this link to join: <https://sbagreaterne.org/news-events/become-a-member/>

2. Complete the application below.
3. Provide an invoice or receipt for eligible expenses. SBAGNE prefers to pay third party vendors directly whenever possible.
 - a. To request direct payment by SBAGNE to a third party vendor, please provide an invoice from the vendor, including payment instructions and organization address and contact information. Upon approval of application, SBAGNE will pay the vendor directly and will provide the applicant with a copy of the receipt for payment for their records.
 - b. If the applicant is applying for reimbursement for out of pocket allowable expenses, all receipts must be submitted with the application. Upon approval of application, SBAGNE will mail a check to the applicant.
 - c. If providing an invoice or receipts as part of the application presents a barrier to your application, please contact the Executive Director to discuss.

What is the review process?

- A. Upon receipt of each application:
 - The Executive Director will review the application in accordance with the current guidelines;
 - If incomplete, Executive Director will communicate to the applicant which components of the application are missing and wait for further response to complete the application.
 - If the application is denied, the Executive Director will communication to the applicant the specific reasons for denial. The applicant may resubmit a revised application.
- B. Upon approval of the application, the Executive Director will:
 - Send direct payment to the third party vendor with a copy of the receipt to the applicant.
 - If reimbursement is sought, will mail a check to the applicant.
- C. *SBAGNE* does not exclude any member from the New England area from applying for an empowerment grant unless the applicant does not have spina bifida.

Questions?

Please contact Jean Bertschmann, Executive Director, at JBertschmann@SBAGreaterNE.org, toll free: (888)479-1900, or office cell: (774)287-2988.



SPINA BIFIDA ASSOCIATION OF GREATER NEW ENGLAND

Annual Empowerment Grant Application 2024

PLEASE WRITE LEGIBLY!

Applicant: _____ **Date of Birth:** _____

Parent/Guardian (if applicable): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone (cell preferred): _____ **Email:** _____

Primary language spoken: _____

Amount requested (annual maximum = \$250): \$ _____

Grant type requested:

- adaptive equipment
- advocacy activity
- assistive technology
- durable medical equipment or supplies
- educational activity
- empowerment activity
- recreation activity and/or equipment
- social activity
- urological supplies for individuals over the age of 3

Payment type requested:

- Direct payment to vendor/provider (invoice with payment method, vendor address and contact information required)
Pay to: _____
Website or mailing address: _____
- Reimbursement to applicant (receipts required)
Pay to: _____
Mailing Address: _____

Please describe specifically what the grant will be used for: _____

Optional:

- I will send the Executive Director a photo of the recipient utilizing the grant award for SBAGNE to share publicly.
- I will send the Executive Director a written statement regarding the impact of this grant award on the recipient for SBAGNE to share publicly.

By signing below, I affirm the following:

- **The applicant is a member of SBAGNE.**
- **The above contact information is accurate.**
- **An invoice for payment or receipts for reimbursement is attached.**
- **The grant beneficiary has spina bifida.**
- **The grant beneficiary 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.**
- **All information provided is true and accurate.**
- **Any photo, video, link, or statement I choose to provide depicting the use or impact of the grant award will be shared publicly by SBAGNE.**

X _____
Applicant or Parent/Guardian Signature

Date: _____

Submit completed application by mail or email to:

Mail: *Spina Bifida Association of Greater New England*
P.O. Box 681
Natick, MA 01760

Email: jbertschmann@SBAGreaterNE.org