



Post Office Box 1346
Kenner, Louisiana 70063
Website: www.sblouisiana.org 504-737-5181 Email: sbla@sblouisiana.org

PLEASE PRINT

Application for MEDICAL Assistance

Name of person for whom aid is being requested: _____

Name of Parent or Guardian (if under 18): _____

Street Address: _____ City: _____

State: _____ Zip: _____ E-Mail address _____

Day Phone: (_____) _____ Night Phone: (_____) _____

Are you currently receiving any additional financial assistance for these expenses? Yes _____ No _____ If Yes, please describe this assistance:

Prior SBLa Cash awards since last October: \$ _____

All of the information contained on this form is true and correct to the best of my knowledge. I hereby give the SBLa permission to verify any of this information. I understand that although a maximum ANNUAL distribution from the SBLa is pre-determined, this amount will only be awarded according to the SBLa allocation policy.

Signed, _____ Date: ____/____/____

This application is for:

_____ Medical Expenses - office visits, procedures, medications (must be Spina Bifida related),

_____ Durable equipment, disposable supplies,

_____Mobility aids (wheelchair, crutches, walker),

Vendor/Hospital: _____

Receipt attached or Bill or Invoice for unpaid amount attached

The Device/Procedure was prescribed by:

_____Prescription attached or Doctor's signed letter attached.

_____Insurance refusal attached.

Rules for Application

1. Application must be for a person with Spina Bifida. A physician statement of disability is required, including the physician's address and phone number.
2. Applicant must reside in the SBLa service area, the State of Louisiana.
3. We reimburse out of pocket expenses only. We will NOT duplicate any expense already paid for by an insurance company or state, federal or private agencies. Must attach denial letters and your appeal letter.
4. All applications must be accompanied by documentation as requested on application.
5. Applications for orthopedic equipment, prescriptions for medications, and corrective treatments all require a prescription or a doctor's signed letter.
6. Checks will be made payable to the provider, unless a paid invoice is provided.
7. All expenditures must have been incurred within 12 months of the application deadline.
8. Awards are paid at a level of 25% of unpaid or out-of-pocket amount, with a Life Time Maximum payout of \$500 per Individual.

Board approved ___/___/___ Board President _____

Amount approved \$ _____ Date check mailed ___/___/___