2017 SBA OF CA SPECIAL ASSISTANCE APPLICATION

Maximum Total Annual Benefit Per Family or Individual with Spina Bifida - $500

Applicant's name: _____ Date of birth: _____

Parent/Guardian name (if applicable): _____

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

Phone: _____ Email: _____

Total amount requested: _____ ☐ Payable to provider ☐ Reimbursement payable to applicant

Requested funds to be used for: _____

_____

Previous involvement in Chapter: _____

_____

Please provide a detailed explanation as to why the SBA of CA should choose to fund your Special Assistance Request:

_____

_____

_____

_____

For questions please contact the Chapter Director, Breanne Walter at bwalter@sbaa.org or *310.359.9611*

By signing below, I affirm the following:

- *All information provided is true and accurate.*
- *The applicant resides in the SBA OF CA service area and has resided in the service area for a minimum of 6 previous months.*
- *The applicant has Spina Bifida.*
- *Applications must be submitted with all necessary accompanying documents. Applications lacking necessary documents will be returned to the applicant.*
- *Requests are voted on by the Chapter Advisory Council on a monthly basis and can take up to three months to be processed depending on the time of year.*
- *Submitting a request does not guarantee the request will be fulfilled.*

The following documentation must be submitted with the application:

- The Applicant has and documentation is provided from a physician. Statement of disability from physician, including address and telephone number of physician. A detailed medical history is not needed.
- **A receipt verifying the cost of the purchase the reimbursement is requested for and or an invoice from the provider of the item they would like the SBA to fund on their behalf.**

All requests will be responded to. If your request does not meet the above listed criteria it will be returned to the applicant.

X_____ Date: _____

Applicant or Parent/Guardian signature

Requests cannot be processed if the following are not included in the application: 1. Proof of Applicant having Spina Bifida, and 2. A receipt showing the amount payed by the applicant or 3. An invoice from the provider showing the cost of the proposed expense.

Submit completed application by mail, fax or email to: Email: Chapter Director – bwalter@sbaa.org
Mail: SBA of CA 1600 Wilson Suite 800 Arlington, VA 22209 or Fax: 202-944-3295