

Spina Bifida and Hydrocephalus Association of Southern Alberta

PO Box 6837 Stn D. Calgary, AB T2P 2E9



FUNDING PROGRAM APPLICATION FORM

Please provide all the information requested and attach **original receipts**, before mailing paperwork to the address above. Kindly allow 4-6 weeks for processing.

Services and materials must be purchased for the individual with Spina Bifida and/or associated Hydrocephalus. Below are the requirements to be eligible:

- A member in good standing with the Spina Bifida and Hydrocephalus Association of Southern Alberta (membership fees up to date, due yearly by Jan 31st, to participate in funding support program).
- A resident of *Southern Alberta* for the past 12 months.
- Have volunteered a minimum of 6-8 hours in the year of application. Family or friends who volunteer on your behalf contribute towards your minimum hours. *Some exceptions may apply with Board approval.
- This fund will only consider the portion of expenses not reimbursed to you by Alberta Aids to Daily Living (AADL), Family Supports for Children with Disabilities (FSCD), private/public medical insurance, Assured Income for the Severely Handicapped (AISH), or any other government a/or disability programs.

Name of Applicant: _____

Information for Individual with Spina Bifida and/or Hydrocephalus (chq will be mailed to this address)

Name: _____ DOB (dd/mm/yyyy): _____

Address: _____

City _____ Province _____ Postal Code: _____

Phone Number: _____ E-mail Address: _____

Volunteer Time (list events, committees, & hours): _____

Total cost of paid receipts for reimbursement: _____

(The maximum allowable amount is up to \$2,500.00 per year). The program funds available may be adjusted by SBHASA if necessary, without notice.

**All requests & original receipts must be received by Jan. 31st for the previous year.

**** Members are not to request funding support from SBHASA if they have also applied for support from any other disability group (example: Easter Seals, AISH, ASLI, AHC, Adaptive Sports Associations, Accessible Housing Society etc.).**

*By signing below, I acknowledge that I have reviewed the Funding Support Program guidelines.

Signature: _____ Date: _____

The SBHASA endeavours to equalize opportunities for individuals with spina bifida and/or hydrocephalus by funding costs which are incurred as result of living with this condition.

Last Revised: March 2024