INCONTINENCE ASSISTANCE REQUEST FORM

The SBANT office has a stock of many types of incontinence supplies including catheters, diapers, briefs and more. Please check with the office to see if supplies are available there before requesting assistance to purchase supplies. Contact Robin Lee at 214-728-9294 or rlee@spinabifidant.org.

Date: ______________________________

Parents name (if applicable): ____

Address:____ City: ____________________________________ Zip Code:______________ Phone # (_____) _________________________

Person with Spina Bifida:________________________ Date of Birth: _________________

Are the submitted expenses only those not covered by insurance, or any other agency? ____Yes ____No

Attached receipts are for the month: ______________________

Total expenses for the month were: __________________

Total of attached dated receipts:_____________________(Photocopies accepted)

*The maximum benefit is $50.00 per month and reimbursement will be calculated At 50% of eligible expenses.

I certify that the above information is true to the best of my knowledge and I am only submitting expenses that qualify under the guidelines of this program. I have not been reimbursed for these expenses by any other group or agency.

Signature:_________________________________ Date: _________________

Please email to information@spinabifidant.org or mail to
SBANT 801 Ave H East Ste 101 Arlington, TX 76011

For committee use only: Eligible: _____Yes _____No
Date :____________________ Check #:___________ Amount $:__________

The SBANT Board of Directors reserves the right to discontinue this Fund when funds have been depleted. Deliberate abuse of the fund will only make it more difficult for SBANT to assist families in future programs.