Financial Assistance Application

Families are invited to request up to $500 of Financial Assistance which can be used for but not including medical assistance, therapy, equipment and more. SBSTL will notify you as soon as possible based on the date the request is received and the next scheduled Board Meeting. Financial Assistance is limited and is offered on a first come, first served basis, annually.

TYPE OF ASSISTANCE REQUESTED:

Please explain: _____

_____

Date: _____

Name of Individual with Spina Bifida: _____

Birth Date: _____

Name of Parents or Guardian (if a minor):_____

Address: _____

Phone: _____Cell:_____

E-mail Address: _____

Amount requested: _____

Check payable to: _____

Please provide a copy of the invoice for the expenses being reimbursed above.

BY SIGINING BELOW I CERTIFY THAT ALL THE INFORMATION PROVIDED IS TRUE AND CORRECT. I CERTIFY THAT THE ITEMS LISTED ARE FOR THE BENEFIT OF THE APPLICANT. IF ANY INFORMATION IS INTENTIONALLY FALSE, I AGREE TO REIMBURSE SBSTL ALL COSTS. LEGAL AND OTHERWISE, TO RECOVER THE DISBURSED FUNDS.

Signature _____

Please send the application for consideration to:

Spina Bifida of Greater St. Louis (SBSTL)
9201 Watson Road, Suite 125
Crestwood, MO 63126

For more Information, call 800-784-0983