Spina Bifida Kansas City
sbkc.org

2017 FINANCIAL ASSISTANCE APPLICATION

FOR COST INCURRED BETWEEN JAN 1 - DEC 31, 2017

Patient's Name:_____ Parent or Guardian:_____

Address:_____ Home Phone: _____

_____ Cell Phone: _____

Patient's Date of Birth: _____ E-Mail Address: _____

Diagnosis: _____

EQUIPMENT (include prescription(s)):

Item(s) Prescribed: ____ Mobility Equipment _____ Orthotics _____Therapy _____ Disposable Med. Supp

Other:_____

Financial Aid Requested:

$_____ Mobility Equipment

$_____ Orthotics

$_____ Therapy

$_____ Disposable Med. Supplies

$_____ Other

EQUIPMENT PROVIDER:

Name: _____

Address: _____

_____

Phone: _____

PRESCRIBING AUTHORITY:

Doctor: _____

Facility: _____

Address: _____

_____

Phone: _____

INSURANCE:

Insurance Coverage? ____Y ____N

Covered Amount: _____

Other Other Relevant Information: _____

_____

I, _____ , give permission to the SB-KC to contact the prescribing authority and equipment provider above for specific information on the patient's case and necessary equipment.

Signature: _____

Relationship to Patient: _____

Date: _____

SBKC USE ONLY
Date Approved:_____
Amount:_____
Check #: _____

SBKC Representative

_____