** 84 Park Avenue, Suite G-106, Flemington, NJ 08822**

**The SBRN Community Fund**

**(for NJ Residents)**

***What is the SBRN Community Fund*?** The SBRN Community Fund (*formerly the DERA Fund*) provides one-time emergency financial assistance to people with spina bifida living in New Jersey who have an emergent/immediate need. The Community Fund helps cover un-reimbursed costs for medical supplies, healthcare services, adaptive equipment, home or car renovations as well as other basic needs (e.g., food or other bills.) *These funds are to be used as the last resort when no other assistance is available.*

***Who Can Apply?*** You can apply for reimbursement if you or your child has spina bifida, are a New Jersey resident and have emergency needs related to your disability.

***What Costs Can I Be Reimbursed For?*** You may be able to receive reimbursement or assistance towards the purchase, repair or replacement of adaptive/specialized equipment (e.g., broken wheelchairs, braces, orthotics, etc.), medical supplies (e.g., catheters, incontinence needs, wound care supplies, etc.), physician’s fees or other medical costs (Note: this fund ***does not cover*** ***co-pays***, the flat fees that you pay at doctors’ visits), medications, home or auto renovations for accessibility, or other basic needs. **Please note that this fund is for immediate/emergency needs only, and not for ongoing needs**.

Other items not mentioned here may be reimbursable if they are in direct response to an urgent need and are related to your disability. If you are unable to cover the costs up front, we may be able to pay the vendor directly if provided with an appropriate invoice.

***Due to limited funding, we may not be able to assist with full cost. The maximum award amount is $300. You can only receive assistance from this fund one time per year.***

***What Information Do I Need to Provide***? You will need:

* A completed application
* Documentation of need for items (e.g., a bill or a note or prescription from a doctor or other professional or some other type of explanation)
* Invoice(s) or receipt(s) for items purchased. (An estimate can be provided for the application, but payment will not be made to the recipient until a receipt is received by SBRN.)

***Who Determines the Financial Awards?*** Recipients and amounts of financial assistance will be determined by SBRN based on need and funding availability.

**SBRN Community Fund Application**

***Date of Application*:** Click here to enter a date.

**1. Name of person with disability:** Click here to enter text.

**2. Date of Birth:** Click here to enter a date. **Gender:** Click here to enter text.

**3. Name of parent or legal guardian (if applicable):** Click here to enter text.

**4. Address:**

 Street: Click here to enter text.

 City: Click here to enter text. State: Click here to enter text. Zip Code: Click here to enter text.

**5**. **Phone:** Click here to enter text. **E-mail:** Click here to enter text.

**6. Yearly Adjusted Gross Income (from your last federal income tax return):** Click here to enter text.

**7. Describe any other financial hardships**: Click here to enter text.

**8. Briefly describe your (or your child’s) medical condition or disability**: Click here to enter text.

**9. TYPE OF ASSISTANCE REQUESTED**: (*please provide receipts/invoices and documentation of need*)

[ ]  **Adaptive or specialized equipment repair/purchase** (wheelchairs, braces, walkers, ramps, etc.)

[ ] **Medical supplies** (catheterization supplies, diapers, incontinence pads, wound care supplies, etc.)

[ ] **Medications** (prescription or over-the-counter)

[ ] **Other medical costs**

[ ] **Home or auto renovations or repairs**

[ ] **Basic Needs** (e.g., food or other necessities)

**10. Briefly describe the emergency/crisis situation and what is needed**: Click here to enter text.

**11. Total Cost**: Click here to enter text. **Date of purchase/payment**: Click here to enter a date.

**12. Name of Vendor/Store**: Click here to enter text.

**13. Do we have permission to share your situation with our funders and other users of the fund?**

[ ]  Yes, but first names only [ ]  Yes, but use other names [ ]  No

**14. Any additional comments:** Click here to enter text.

**Please return completed applications with documentation to one of the following**:

* **Email:** info@thesbrn.org
* **Mail:** Spina Bifida Resource Network

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**Questions?** Please contact us at info@theSBRN.org or 908-782-7475