SPINA BIFIDA ASSOCIATION OF GREATER NEW ENGLAND

Annual Empowerment Application 2021
Maximum total benefit for 2021 - $250

Applicant: _____ Date of Birth: _____

Parent/Guardian (if applicable): _____

Address: _____ City:_____ State: ____ Zip:_____

Phone: _____ Email: _____

For the **OFFICIAL POSTING, log onto www.SBAGreaterNE.org** **For questions,** email Jean Bertschmann at JBertschmann@SBAGreaterNE.org or call our office at 1-888-479-1900.

Reimbursement for: _____
_____
_____
_____

Check payable to provider on attached invoice for $_____
Make check payable to:
Mailing Address:

Amount Requested with this application: $ _____

By signing below, I affirm the following:

- ***All information provided is true and accurate.***
- ***The above contact information is accurate.***
- ***I am a member of SBAGNE.***
- ***The applicant has Spina Bifida and documentation is provided from a physician. Distributions will not be made until documentation has been provided.*** Statement of disability from physician, including address and telephone number of physician. If you have provided this information in previous years SBAGNE has it on file and it is not required. A *detailed medical history is not needed.*
- ***The applicant resides in the SBAGNE service area.***
- ***If a portion of the application is deficient or if there is a question of residency, SBAGNE reserves the right to clarify and/or request additional information for the benefits***.

X_____ Date: _____
Applicant or Parent/Guardian Signature

Submit completed Application by mail, fax or email to:

Mail: ***SBAGNE***
219 East Main St, Suite 100B
Milford, MA 01757

Fax: 508-482-5301
Email: jbertschmann@SBAGreaterNE.org