



Spina Bifida and Hydrocephalus Association of Manitoba

167 Lombard Ave., Suite 647, Winnipeg, MB R3B 0V3

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spinabifidamanitoba@gmail.com

Charitable Registration #862738853RR0001

The Spina Bifida and Hydrocephalus Association of Manitoba is a registered charitable organization which strives to improve the quality of life for people affected by Spina Bifida and Hydrocephalus through support, education, advocacy, research and funding.

We provide services and support to persons with Spina Bifida and Hydrocephalus and to their families, caregivers, medical and educational professionals. Our objective as a volunteer association is to act as a resource to individuals and families by determining needs for and providing physical, emotional, and financial support, information on legal, educational, financial and vocational opportunities.

SBHAM BENEVOLENT FUND

Purpose	The purpose of the SBHAM Benevolent Fund is to relieve conditions associated with disability by providing gift cards or vouchers to cover food costs while in the hospital for extended stays.
Value	Up to \$100, once or twice per year.
Eligibility	This fund is available to those who live in Manitoba, have Spina Bifida and/or Hydrocephalus and/or are caregivers of those who are affected by Spina Bifida and/or Hydrocephalus. The applicant also must be a member of the Spina Bifida and Hydrocephalus Association of Manitoba (http://www.sbham.ca/membership). Applicants are eligible to receive this fund once or twice a year.
Qualifications	Applicants are to submit their receipts for appropriate expenses (such as food and drink) the attached application form and documentation of their hospital stay that includes dates, hospital and doctor. These expenses are to be submitted by December 31, 2015. The SBHAM board will make a decision on reimbursement based on need and funds available.
Information	Spina Bifida and Hydrocephalus Association of Manitoba 647-167 Lombard Avenue Winnipeg, Manitoba R3B 0V3 www.sbham.ca spinabifidamanitoba@gmail.com
Advertise	Fund will be advertised on SBHAM's website www.sbham.ca , SBHAM Facebook page, at the Rehabilitation Centre for Children Skye Resource Centre, and Doctor's Offices.

EMERGENCY HOSPITAL FUND APPLICATION

Name: _____

Address: _____ City: _____ Prov. _____

Postal Code: _____ Phone: () _____

Are you the applicant or the caregiver? _____

Caregiver's Name: _____

Address: _____ City: _____ Prov. _____

Postal Code: _____ Phone: () _____

Name of Hospital: _____

Dates of Admission: _____ Date of Discharge _____

Name of Doctor: _____ Doctor's Phone: () _____

Purpose of Hospital Stay: _____

Have you received this funding before? _____

If yes, please provide the date & amount: _____

I am a member of the Spina Bifida and Hydrocephalus Association of Manitoba

Expenses Incurred During Hospital Stay:

Date	Name of Vendor	Purpose	Cost	Approval

Please ensure you have included:

- Original copies of your receipts (up to \$25)
- Proof of hospital stay including attending doctor, date & hospital
- All contact information
- Mail to: **Spina Bifida and Hydrocephalus Association of Manitoba**
647-167 Lombard Avenue
Winnipeg, Manitoba R3B 0V3

All submissions remain strictly confidential. The board will advise on whether or not they were able to approve your requests.