

# SPINA BIFIDA OF WESTERN NEW YORK, INC.

137 Warner Avenue, North Tonawanda, New York 14120

Telephone: (716) 446-5595

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## HOSPITALITY FUND APPLICATION

Date of Application \_\_\_\_\_

Name of Person (with SB, hydrocephalus or related neural tube defect) Requesting Aid:

\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Check One: Child \_\_\_\_\_ Adult \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If child, name of parent requesting grant: \_\_\_\_\_

How long have you been a dues-paying member of the SBWNY? \_\_\_\_\_

Which SBWNY Committee or function have you been assisting with? \_\_\_\_\_

Length of hospital stay (24 hour minimum): \_\_\_\_\_

Reason for hospitalization: \_\_\_\_\_

Dates of procedure(s): \_\_\_\_\_

Type of expense(s): \_\_\_\_\_ Amount: \_\_\_\_\_

Fund eligibility and the amount awarded are solely at the discretion of the fund's administrative committee. The SBWNY Board of Directors reserves the right to discontinue this fund at any time or if all funds have been depleted.

Please refer to the reverse side of this application for the "Hospitality Fund Rules of Operation."

Send this completed application along with a discharge order from the hospital showing the dates you were admitted and discharged and *original* receipts to one of the following Hospitality Fund Administrative Committee members:

Primary: Pam Morris  
137 Warner Avenue  
N. Tonawanda, NY 14120

Alternate: Karen Savanyu  
1709 Beaver Meadow Road  
Java Center, NY 14086

**FOR SBWNY USE ONLY:** Current dues paid? Circle YES or NO Date paid: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Paid by: \_\_\_\_\_ Date: \_\_\_\_\_ Check # \_\_\_\_\_

## HOSPITALITY FUND RULES OF OPERATION

Effective January 1, 2008

1. Spina Bifida of Western New York, Inc. (SBWNY) Board of Directors reserves the right to amend these rules and to discontinue this fund if/when funds have been depleted.
2. All fund recipients are encouraged to be current dues paying members of the SBWNY.
3. All fund recipients are encouraged to volunteer on a committee or assist with a SBWNY function or fundraiser. Fund recipients will be added to a volunteer database and they may be called upon occasionally to assist with functions and/or fundraisers.
4. All fund recipients must reside in SBWNY's service area, which includes only the following New York counties: Erie, Niagara, Allegany, Orleans, Cattaraugus, Chautauqua, Wyoming, and Genesee.
5. **Original** receipts must accompany all fund requests.
6. Applications for reimbursement of prior year expenditures must be submitted no later than March 31. No prior year applications will be accepted after that date.
7. Eligible expenses include the following types of expenses directly related to the hospital stay: telephone expenses, television rental, parking fees, meals for immediate family (parents and/or siblings).
8. Funds are available up to a yearly maximum of \$100.00 per person, based on availability of funds. Grant eligibility and amount are solely at the discretion of the fund's administrative committee. Funds are not guaranteed. In the event that an application is denied, the applicant will be notified in writing.
9. An application, along with **original** receipts, and a discharge order from the hospital showing the dates you were admitted and discharged (24-hour minimum stay required), must be submitted with each request. The SBWNY treasurer will issue payment within 30 days of receipt of the administrative committee's approval and depending upon availability of funds.
10. Applications may be obtained from the following Hospitality Fund Administrative Committee members:

Primary: Pam Morris  
137 Warner Avenue  
N. Tonawanda, NY 14120  
Phone: (716) 694-8567

Alternate: Karen Savanyu  
1709 Beaver Meadow Road  
Java Center, NY 14086  
Phone: (585) 457-9867

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