BOBBY JONES OPEN
SYRINGOMYELIA ASSISTANCE PROGRAM

Application Procedures

To be considered for the Bobby Jones Open Syringomyelia Assistance Program, you will need to:

- **Be a current member of the American Syringomyelia Alliance Project, Inc.**
- **You may not apply if you have previously been awarded the Bobby Jones Open grant.**
- **Complete the CONFIDNETIAL APPLICATION (attached) and have the PROFESSIONAL VERIFICATION and AUTHORIZATION filled out by the appropriate person.**
- **Receive a written quotation for the total cost (including applicable taxes, if any) of the item(s) from the vendor so the check can be made out to you and the seller.**
- **Mail the CONFIDENTIAL APPLICATION and the PROFESSIONAL VERIFICATION AND AURHORIZATION AND QUOTATION forms to ASAP for review and approval. (Non-qualifiers will be notified by mail.)**
- **Upon acceptance into the program, you will receive a check to be used for the reason(s) you noted in the application.**
- **Please mail the application to:**

ASAP
PO Box 1586
Longview, TX 75606-1586

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CONFIDENTIAL APPLICATION

Please read each question and answer as thoroughly as possible.

Name:_____

Address:_____

City:_____**State:**_____**Zip:**_____

Home Phone #: (_____)_____ **Work Phone #: (_____)**_____

Date of Birth:_____**Sex:**_____**SSN#:**_____

Are you a member of ASAP? Yes_____No_____
Have you previously applied for the Bobby Jones Open Grant? Yes_____No_____
Date you received definite diagnosis of syringomyelia and/or Chiari malformation?_____

Describe your disability and how it affects your daily functioning.

_____

_____

_____

_____

What type of adaptive equipment or assistance are you applying for and how much do you anticipate it will coast? (Maximum for this grant is $1,000.)

Item(s):_____**Cost (include tax,etc.)**_____

Name of selling Company:_____

Be sure to send a written quote on the seller's letterhead/stationery.

Who first suggested that this item would be helpful to you?

Name:_____**Title:**_____

Address:_____

City:_____**State:**_____ **Zip:**_____**Phone #:**_____

Do you know where and how the item(s) can be purchased? Explain:

_____

_____

_____

_____

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Describe in detail why you believe the adaptive equipment or assistive device you are seeking through the BJO SAP would be helpful to you. How would you use it? For example, would it be used to increase your productivity in the workplace, increase your mobility, or improve your independence in self care activities?

_____

_____

_____

_____

Is it your plan to pay part of the expenses yourself, have another family member or friend pay part of the expenses or have another agency or service provide some of the funds that may exceed the $1000 grant? Yes:_____ No:_____
Explain:_____

_____

Have you sought any other sources of funding for the item you are requesting a grant for, such as Vocational Rehabilitation, Easter Seals, Independent Living Centers, Medicare, Medicaid, private insurance or other state or local resources? Yes:_____ No:_____
If yes, explain:_____

_____

What is your current source of support?_____

Are you and/or your spouse employed? Yes_____ No:_____ Where?_____

Do you get benefits from Social Security _____ SSI_____ Retirement _____

Welfare _____ Other _____? Explain:_____

Number of persons in household: _____ Total annual income: $_____

Other explanations or comments: (use additional sheets if necessary):_____

_____

_____

_____

_____

_____

By signing this I verify that all information is correct and accurate.

Signature: _____Date:_____

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PROFESSIONAL VERIFICATION AND AUTHORIZATION
CONFIDENTIAL APPLICATION

Primary physician: Name:_____

Address:_____

City:_____**State:**_____ **Zip:**_____**Phone #:**_____

Doctor's explanation and/or verification of need for equipment:

_____

_____

_____

Physician's signature:_____**Date:**_____

Physical Medicine, Surgeon, or other Specialist:

Name:_____**Title:**_____

Address:_____

City:_____**State:**_____ **Zip:**_____**Phone #:**_____

Doctor's explanation and/or verification of need for equipment:

_____

_____

_____

Specialist's signature:_____**Date:**_____

Paramedical Professional: Prosthetist, Orthotist, Physical Therapist, Home Health Care Nurse, Occupational Therapist, Medical Social Worker, etc.
Name:_____**Title:**_____

Address:_____

City:_____**State:**_____ **Zip:**_____**Phone #:**_____

Doctor's explanation and/or verification of need for equipment:

_____

_____

_____

Physician's signature:_____**Date:**_____

Prefer two signatures. Require at least one MD signature.