## **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 CONFIDENTIAL 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 AUTHORIZATION 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

### **CONFIDENTIAL APPLICATION**

Ivanic:			
Address:			
City:			Zip:
Home Phone #: ()		: #: ()	
Date of Birth:	Sex:	SSN#:	
Are you a member of ASAP? Yes Have you previously applied for the Date you received definite diagnosis	Bobby Jones Open Gr	ant? YesNo or Chiari malform	o ation?
Describe your disability and how it a	affects your daily funct	ioning.	
What type of adaptive equipment or anticipate it will coast? (Maximum f			much do you
Item(s):		_Cost (include tax	,etc.)
Name of selling Company:			
Be sure to send a written quote on th	ne seller's letterhead/st	ationery.	
Who first suggested that this item we	ould be helpful to you?	,	
Name:		Title:	
Address:			
City:St	ate:Zip:	Phone #	:
Do you know where and how the iten			
•		•	

#### **CONFIDENTIAL APPLICATION**

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: \_\_\_\_\_

#### PROFESSIONAL VERIFICATION AND AUTHORIZATION CONFIDENTIAL APPLICATION

Primary physician: Name	<u>.</u>				
Address:					
			Phone #:		
Doctor's explanation and	/or verification of no	eed for equipme	nt:		
Physician's signature:			Date:		
Physical Medicine, Surge			Datt		
Name:			Title:		
Address:					
			Phone #:		
Doctor's explanation and	or verification of no	eed for equipment	nt:		
Specialist's signature:			Date:		
			erapist, Home Health Care Nurse,		
Occupational Therapist, I Name:		-	Title:		
			Phone #:		
Doctor's explanation and	/or verification of ne	eed for equipme	nt:		
Physician's signature:			Date:		

Prefer two signatures. Require at least one MD signature.