BOWEL & BLADDER MANAGEMENT APPLICATION

Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: (204) _____

Are you the applicant or the caregiver? _____

Caregiver's Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: (204) _____

Name of Doctor: _____ Dr.'s Phone: (204) _____

Description/Name of Disability: _____

_____

_____

Have you received this funding before: _____

If yes, please provide the date & amount: _____

_____ I am a member of the Spina Bifida & Hydrocephalus Association of Manitoba

Expenses Incurred:

Please ensure you include:

_____ Original copies of your receipts (up to $500)

_____ All contact information

_____ Mail to: **Spina Bifida & Hydrocephalus Association of Manitoba**
P.O. Box 333 210-1600
Kenaston Blvd.
Winnipeg, MB R3P 0Y4

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