ABLE BIONICS USA

Bridging Bionics FOUNDATION

2019 SCHOLARSHIP APPLICATION

(Note: All information contained in this application will be kept confidential.)

Applicant Information

Name: _____

Street Address: _____

_____

County of residence: _____
(For example: Pitkin County)

County of work: _____

Contact Phone: _____

Email Address: _____

Date of Birth: _____

US Citizen: Yes _____ No _____

Driver's License ID: _____

OR Other Government Issued ID: _____

Name of person filling out application: _____

Relationship to Applicant: _____

Diagnosis

Medical neurological diagnosis/injury: _____

Date of diagnosis/injury? _____

Cause of injury? _____

Physician / Rehabilitation Information

Primary Care Physician: _____

Address (office): _____

Contact number: _____

Primary Rehabilitation Therapist: _____

Address (clinic): _____

Contact number: _____

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Financial Information

Marital status: _____ Single _____ Married

Number of dependents: _____

Annual Income: $_____

Source(s) of Income: _____

Please note that Bridging Bionics Foundation may request proof of income in the form of a tax return or bank statement. All information is confidential and is used only for the purpose of evaluating your request.

Healthcare

The following information is helpful for us to know, as the Able Bionics USA program is a charitably funded initiative. We recognize that Medicare/Medicaid and some insurance companies currently do not reimburse for Galileo Training Systems or exoskeleton therapy.

Do you have health insurance? _____ Yes _____ No

Name of Insurance: _____ Policy type: _____

Do you have Medicare/Medicaid? _____ Yes _____ No

1. *Medicare is a federal program that provides health coverage if you are 65 or older or have a severe disability, no matter your income.*
2. *Medicaid is a state and federal program that provides health coverage if you have a very low income.*

If you are eligible for both Medicare and Medicaid (dual eligible), you can have both.

Services Needed

Able Bionics USA Program Sponsorship _____ Yes _____ No

Duration: _____

How will this sponsorship help you? _____

_____

_____

_____

Briefly describe your immediate needs or concerns: _____

_____

_____

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Is there anything else you would like to tell us about yourself? _____

_____

_____

_____

Bridging Bionics Foundation believes in the expression of "paying it forward". How have you, or how do you, plan to pay it forward? _____

_____

_____

Waiver and Truth Statement

"Any decision by Bridging Bionics Foundation (BBF) and Able Bionics USA (ABUSA) as to: a) whether or not a sponsorship is to be awarded and b) if awarded, in what amount and the terms and conditions attaching thereto, shall be made in the sole and absolute discretion of ABUSA/BBF. Sponsored applicants in the Able Bionics USA program will agree to adhere to a 24-hour cancellation policy for scheduled sessions. If a session is cancelled by the sponsored applicant within 24-hrs and is not considered an emergency, the sponsored applicant agrees to pay for the actual cost of the session (which is $75/hr). By your submission of this sponsorship application to BBF, you agree to be bound by the decision of ABUSA/BBF and indemnify and hold ABUSA/BBF harmless from any and all claims, actions and/or causes of action arising directly or indirectly as a result of ABUSA/BBF's decision."

ABUSA/BBF uses sponsorship bios and related media (photos/videos) to assist in fundraising efforts to complete our mission. The statements and answers given in this sponsorship application are true and correct. I understand that misstatements in this sponsorship application could cause my application to be denied.

☐ I AGREE

Applicant's Name (please print): _____

Signature: _____ Date: _____

If under the age of 18, please have parent or guardian sign this Request

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____