Kya's Krusade Financial Assistance Program
Adaptive Equipment Application

http://www.kyaskrusade.org

Application #_____
Date Received _____
(To be completed by Kya's Krusade)

Child's Information

Name _____ Birth date _____ Age _____ Gender _____

Physical Disability _____ Age at Diagnosis _____

Primary Health Care Coverage (check all that apply):

_____ Insurance _____ Medicaid Other:_____

Parent/Legal Guardian's Name(s)_____

Number of Family Members _____ Family Members contributing to Household Income _____

Annual Household Income

___ less than $25,000 ___ $25,000 - $40,000 ___ $40,000-$60,0000 ___ $60,000 – $90,000 ___ $90,000 +

Applicant's Information

Name _____ Relationship to Child _____

Address _____ E-mail Address _____

_____

Day Phone Number _____ Evening Phone Number _____

Notification (Parent's) Address _____

_____

Pediatrician or Physician Information

Name _____ Medical Practice Name _____

Address _____ Phone Number _____

_____ Fax Number _____

E-mail and/or Website Address _____

Physical or Occupational Therapist Information

Name _____ Clinic/Rehab Facility Name _____

Address _____ Phone Number _____

_____ Fax Number _____

E-mail/Website Address _____

Frequency of therapy sessions attended _____ times per ____ week ____ month ____ year

Kya's Krusade Financial Assistance Program
Adaptive Equipment Application

http://www.kyaskrusade.org

Adaptive Equipment Information

Product Name(s) _____

Product Description(s) _____

Preferred Manufacturer(s) _____

Preferred Vendor(s) _____

Vendor's Website Address and Phone Number _____

Vendor's Product Identification Number(s) _____

Cost of Equipment $_____

Amount of Assistance Requested $ _____

Preferred type of assistance: _____ Please order the requested equipment for me.

_____ Please provide me with a retailer gift card, if it is available.

- Please submit an itemized list for the products & prices if more than one piece of equipment is requested. Items may be requested from no more than two preferred vendors.
- Gift cards will only be issued for retailers that specialize in adaptive equipment and for amounts less than $250, at the discretion of the Financial Assistance Committee and Board of Directors.

** Kya's Krusade reserves the right to choose a different vendor or manufacturer if the identical adaptive equipment can be obtained at a lower price or from a more reputable vendor or manufacturer. Vendors must be verified by the Financial Assistance Committee and must be based in the United States.

If you do not receive assistance during this cycle, would you like your application to be considered during the next cycle? _____ Yes _____ No

Application Checklist:

The Completed Application
Parental Consent and Liability Release Form
Physician Medical Diagnosis Verification Form
Physical/Occupation Therapist Reference Form

Please send all completed, signed original copies of the application materials to:

Kya's Krusade
947 E. Johnstown Rd., Ste. 143
Gahanna, Ohio 43230

I certify that all information provided above is accurate and complete. I have the authority to submit this application on behalf of this child as her or his parent or legal guardian or with the permission of her or his parent or legal guardian.

_____ _____

Print Name **Date** **Signature** **Date**

Relationship to the Child _____

Kya's Krusade Financial Assistance Program
Adaptive Equipment Application

http://www.kyaskrusade.org

Diagnosis Verification Form

This form must be completed and submitted by the Child's current Pediatrician or Physician.

Child's Name _____

Adaptive Equipment Requested _____

Application Submission Deadline _____/ _____/_____

Physician's Name _____

Specialty _____ **Physician's ME Number** _____

State(s) in which Physician is licensed to practice _____

Name of Practice _____

Physician's Office Address _____

_____

Phone Number _____ **Fax Number** _____

As a physician of _____, I verify the following concerning this child (please check all that apply):

_____ (S)he is one of my current patients (has been seen by me during the past 12 months)

_____ Has a diagnosis of _____.

_____ Was born on _____/ _____/_____.

_____ Was diagnosed at the age of _____ with this condition.

_____ In my professional opinion, the child could benefit from the requested equipment.

Additional Comments:

I have been informed of the applicant's intent to apply for Financial Assistance from Kya's Krusade for the purpose of purchasing adaptive equipment. I understand that my office will be contacted to verify that I have sent and signed this form as part of the application process.

_____ _____

Physician's Name **Date** **Physician's Signature** **Date**

Kya's Krusade
947 E. Johnstown Rd., Ste. 143 · Gahanna, Ohio 43230

"A gateway to hope and support, where family, medical and social communities converge."

Kya's Krusade Financial Assistance Program
Adaptive Equipment Application
http://www.kyaskrusade.org

Physical or Occupational Therapist Reference Form
This form must be completed and submitted by the Child's current Physical or Occupational Therapist.

Child's Name _____

Adaptive Equipment Requested _____

Application Deadline _____/ _____/_____

Therapist's Name _____ **License Number** _____

Professional Therapy Designation ____ **Physical** _____ **Occupational** _____ **Other:** _____

Clinic or Rehabilitation Center Name _____

Address _____ **E-mail** _____

_____

Phone number _____**Fax Number** _____

As a Physical/Occupational Therapist of _____, I am able to verify the following concerning this child (please check all that apply):

_____ (S) he is one of my current patients (has been seen by me during the past 12 months)

_____ Has a diagnosis of _____.

_____ Was born on _____/ _____/_____.

_____ Was diagnosed at the age of _____ with this condition.

_____ In my professional opinion, the child could benefit from the requested equipment.

_____ Attends _____ therapy sessions per _____week _____ month _____ year

Additional Comments:

I have been informed of the applicant's intent to apply for Financial Assistance from Kya's Krusade for the purpose of purchasing adaptive equipment. I understand that my office will be contacted to verify that I have sent and signed this form as part of the application process.

_____ _____

Therapist's Name **Date** **Therapist's Signature** **Date**

Kya's Krusade
947 E. Johnstown Rd., Ste. 143 · Gahanna, Ohio 43230
"A gateway to hope and support, where family, medical and social communities converge."

Kya's Krusade Financial Assistance Program
Adaptive Equipment Application

http://www.kyaskrusade.org

Parental Consent and Release from Liability

I, the undersigned, am the parent or legal guardian of _____ (child's name).

- I hereby give my permission for the applicant _____ (applicant's name) to submit a Kya's Krusade Financial Assistance Program Equipment Application on behalf of my child.
- I certify that I have thoroughly reviewed the application guidelines and the application prior to its submission and that all information provided is accurate and complete.
- I grant Kya's Krusade associates permission to contact my child's Physician and Physical or Occupational Therapist for the purpose of verifying the Diagnosis Verification Form and Therapist Reference Form.
- The stated applicant, not Kya's Krusade, is liable for any fraudulent actions or activities associated with the submission and resulting processing of this application.
- I understand that Kya's Krusade is not a manufacturer of adaptive equipment or aid. Kya's Krusade, its associates, agents and employees are not liable for any claims, judgments or punitive damages associated with the receipt, use, quality or associated injuries incurred from the purchased product(s) using funds distributed through the Financial Assistance Program.

_____ _____

Parent's Name **Date** **Parent's Signature** **Date**

Kya's Krusade
947 E. Johnstown Rd., Ste. 143 · Gahanna, Ohio 43230
"A gateway to hope and support, where family, medical and social communities converge."