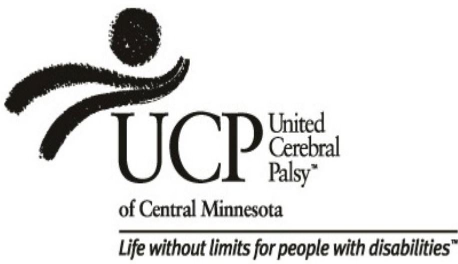


Request Rec'd_________
(Office use only)

EQUIPMENT GRANT APPLICATION

Person Receiving Assistance_____________________________________ Telephone#__________________

Address____ Birthdate____________________

City__________________________State_________Zip_______________County______________________
(**must reside in Stearns, Benton or Sherburne**)

Type of disability?____

Person completing this form (if other than person receiving assistance)________________________________

Relationship__________Telephone #____________________ Email________________________________

Number of Persons in Family: Adults________: # of dependent children_____ & Ages_________________

Number of Persons in Family Currently Employed____

For what purpose are you requesting financial assistance? Please list items and cost. Attach any supporting documentation such as therapist's recommendations, picture of equipment, etc. Equipment is for personal use, not for use in school. If there are several items, please rank them in order of importance. It would be helpful to include a photo of the recipient.

Item	Description, Product #	Supplier/Vendor	Cost
__________________	_________________________	____________________	__________
__________________	_________________________	____________________	__________
__________________	_________________________	____________________	__________

How will this item increase the independence or benefit the person using it:
____
____

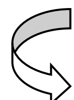
Have you had the opportunity to try this item? Is so, what were the results?___________________________
____

Has this equipment been recommended by a professional, such as a P.T., O.T. or Speech therapist?________

Who referred you to our agency? Name____

Job Title______________________________ Email____

Place of employment____ Phone #________________________



Continued on other side

Are you receiving benefits from: SSI______________ SSDI_______________ TEFRA_______________

Do you have health insurance?_____________ Do you receive Medical Assistance?___________________

Does your insurance company cover any or part of this equipment?_________________________________

List any other funding sources contacted for assistance. What was their response?_____________________

____

If necessary, could you contribute toward a portion of the cost of this equipment? Yes_____; No_____.

UCP expects you to pay the shipping costs.

UCP also requires a thank you note along with a picture for our grant records when the equipment is received

CONSENT TO RELEASE PRIVATE DATA

Parent (s)/Applicant: This consent allows information about your child/you to be exchanged with other professionals.

Name____ Parent____; Guardian_____; Applicant_____;

Address:____

____Telephone:_________________________________

I authorize United Cerebral Palsy of Central Minnesota to obtain information from other sources regarding my request: Information may be requested from (*please check all that may apply*):

Physical/Occupational/Speech therapist:____; Physician____; Teacher_____; Other (please specify) ________.

I understand that this authorization takes effect the day that I sign it. It expires on _____________________
(Month, Day, Year) or no more than one year from date of my signature.

I understand that I may change this authorization at any time. Upon receiving funding, I also agree to send a thank you note and photo which UCP could use to promote this program to other funding sources.

____ ____

Parent/Applicant Signature Month/Day/Year

Please return this form to U.C.P., 510 25th Avenue North, St. Cloud, MN 56303.
Tele: 320-253-0765; Toll Free (MN only) 1-888-616-3726; Fax: 320-253-6753; Email: info@ucpcentralmn.org
Review meetings are held monthly on the first Wednesday. You will be notified of the committee's decision.
www.ucpcentralmn.org

(modified 6/14 Equipment Grant Application)