UNITED CEREBRAL PALSY OF THE GOLDEN GATE
DEVICE/EQUIPMENT GRANT APPLICATION

APPLICANT INFORMATION

Name _____ Age _____

Address _____ Phone No. ( )

City, Zip Code _____ Email _____

EQUIPMENT REQUESTED *[My include hi-tech devices (i.e. AT/AAC*) or basic equipment (i.e. wheel chair)]*

(AT/AAC or therapy devices should have been prescribed by a licensed therapist or physician)

Specific device or equipment (Make/Model) _____

_____

Was the requested item previously prescribed? (If yes, fill out prescriber info below)

❒ Yes
❒ No

Prescriber (i.e., physician/ SLP/PT/OT/Job Coach) _____

Name

_____

Address

_____

Phone No.

Has the item been requested through insurance?

❒ Yes
❒ No

If yes, was the item approved by the applicant's insurance?

❒ Yes
❒ No

How much of the cost, if any, will the applicant's health insurance pay for? (Please provide documentation from insurance(s) upon approval) _____

LIFE IMPACT *(Can be completed by applicant, family member, or clinical professional - i.e., physician/therapist/caregiver/aid, etc.)*

1. What impact(s) will this equipment have on the quality of the applicant's life? Specifically, how will this equipment increase independence, improve access, or provide other desirable outcomes?

_____

_____

_____

_____

2. Has the applicant received any assistive technology equipment or devices in the past? If yes, what impact did it have on the applicant's life?

MEDICAL INFORMATION

Medical Condition/Diagnosis

Insurance Provider(s)
(i.e., private, Medicare, Medi-Cal, regional center)

Physician(s) Name and Contact Info

Name	Name
Address	Address
Phone/Email Address	Phone/Email Address

THERAPIST/SERVICE PROVIDERS

Name, Organization and Contact Info

Name	Name
Organization	Organization
Address	Address
Phone/Email Address	Phone/Email Address

All responses will remain confidential and will only be used for the purpose of determining awardees for the AT Device/Equipment Grant.