Section 9 / Part 22
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# United Cerebral Palsy Application for Financial Assistance – Independent Living Assistive Technology Services

*Individuals served under this grant must meet the following eligibility criteria and procedures:*

* If services are provided solely to assist an individual with a severe disability to secure or engage in employment, and if the individual is also eligible for Vocational Rehabilitation services, the services must be provided under the Vocational Rehabilitation program.
* Recipients must have a significant physical or developmental disability such as cerebral palsy, spina bifida, autism, spinal cord injury, head injury, hearing impairment, visual impairment, etc.
* Recipient must be a Kansas resident.
* The SRS share of individual grants will not exceed **$2,500** and must be matched at least 50/50 by outside funding sources or the recipient.
* Requests will be funded primarily on a first come-first serve basis. The only exception being that persons on the existing SRS durable medical equipment waiting list will be given initial priority in submitting requests. Further, UCP will be allowed discretion in prioritizing requests so that recipients represent a "reasonable" geographical dispersion across the state.
* Computers may be purchased as part of a communication or other AT system. Computers cannot be purchased as a free standing piece of equipment, or for school age individuals.
* SRS limits cost sharing to the lift mechanism for lift chairs.
* SRS restricts the purchase of hearing aids. UCP-K is allowed discretion in determining eligibility on an individual basis.
* Recipients will be subject to the UCP-K financial eligibility criteria.

For more information, call Dave Jones at (316) 688-1888 or (785) 266-2266.

**United Cerebral Palsy Application For Financial Assistance**

Client's Name_____

Age_____ Birthdate _____

Address_____

City_____ State_____ Zip_____

Phone ( )_____

Parent's Name(s) [if client is a minor]_____

Father's place of employment_____

Mother's place of employment_____

Disability or diagnosis_____

Date of onset of disability (at birth)_____ other_____

Equipment requested_____

Total cost $_____ Amount family can contribute toward cost $_____

Amount requested from UCP $_____

Have other agencies or groups been contacted for assistance? Yes____ No____

If yes, which ones and what were the results? _____

Will your personal insurance cover any or all of the equipment requested?

Yes_____ No_____ If yes, how much? _____

Name of the insurance company_____

Is client eligible for and/or receiving assistance from: (circle one)

Aid To Dependent Children Yes No

Social Security Yes No

Supplemental Security Income (SSI or SSDI) Yes No

Kansas Special Health Services Yes No

Medicaid Yes No

Medicare Yes No

Do you have a prescription or professional recommendation for the item requested? Yes_____ No_____ If yes, from whom? _____

Gross annual family income $_____

Number of persons living in the household_____

I verify that the information provided above is accurate and agree to complete a follow-up questionnaire if provided with financial assistance.

Signed_____

Date_____

Please return to:

UCP of Kansas
PO Box 8217
Wichita, KS 67208