



Request Rec'd _____
(Office use only)

Adaptive Equipment Connection Program

Person Receiving Assistance _____ Telephone# _____

Address _____ Birthdate _____

City _____ State _____ Zip _____ County _____
(must reside in Stearns, Benton, Sherburne or Watkins school district)

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 equipment support? 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 resale. If there are several items, please rank them in order of importance.

<u>Item</u>	<u>Description, Product #</u>	<u>Supplier/Vendor</u>	<u>Cost</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Have you had the opportunity to try this item? _____

Who referred you to our agency? Name _____

Email _____

Phone # _____

Are you receiving benefits from: SSI _____ SSDI _____ TEFRA _____

Do you have health insurance? _____

Do you receive Medical Assistance? _____

You will be responsible for 10-20% of the total cost. We will request to take photo of the recipient with the equipment.

CONSENT TO RELEASE PRIVATE DATA

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

I authorize ConnectAbility of MN to obtain information from other sources regarding my request:

Information may be requested from *(please check all that may apply)*:

___ Physical/Occupational/Speech therapist: name and phone _____

___ Physician: name and phone _____

___ Teacher: name and phone _____

___ Other: name and phone _____

I understand that this authorization takes effect the day that I sign it and expired in one year.

I understand that I may change this authorization at any time.

Upon receiving funding, I also agree allow ConnectAbility to take a photo of the recipient and the equipment for marketing, grant reporting, and promoting the program.

Parent/Applicant Signature

Month/Day/Year

***Please return this form to ConnectAbility of MN, 24707 County Road 75, Saint Augusta, MN 56301.
Tele: 320-253-0765; Fax: 320-253-6753; Email: Hello @ConnecyAbilityMN.org
Review meetings are held monthly on the third Wednesday. You will be notified of the committee's decision.***

