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.

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? _____

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: 2700 1st Street North, suite 200, Saint Cloud, MN 56303
Tele: 320-253-0765 Fax: 320-214-2020 Email: Hello @ConnectAbilityMN.org
Review meetings are held monthly on the third Wednesday. You will be notified of the committee's decision.

ConnectAbility of MN

CENTRAL MINNESOTA Community Foundation

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