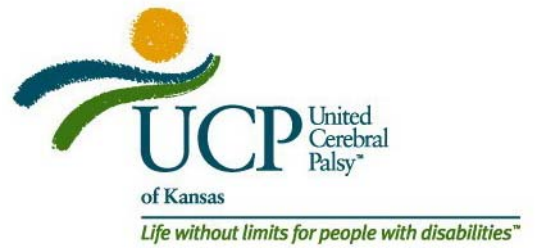


UNITED CEREBRAL PALSY OF KANSAS

Application for Financial Assistance



Client's Name _____ Age _____ Date of Birth _____
 Address _____ City _____ County _____ State _____
 Zip Code _____ Phone () _____ Alternate Phone () _____

Parent's Name(s) (if client is a minor) _____
 Father's Place of Employment _____ Mother's Place of Employment _____
 Client'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 any other agencies or groups been contacted for assistance? Yes _____ No _____
 If yes, which agencies and what was the outcome _____

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)

Health Wave	Yes	No	Supplemental Security Income (SSI or SSDI)	Yes	No
Social Security	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 I agree to complete a follow-up questionnaire if provided with financial assistance.

Signature _____ Date _____

Please return to: UCP of Kansas
 P.O. Box 8217
 Wichita, KS 67208
 FAX (316) 688-5687
 davej@ucpks.org