



APPLICATION for CUSTOMIZED WHEELCHAIR

Name of Child _____ Gender _____ Age _____
 Date of Birth: _____
 Disability and/or diagnosis _____
 Current Method of Mobility _____
 Parent(s) / Guardian Name _____
 Street Address _____ City _____ Zip _____
 Home Phone _____ Alt Phone _____
 Current School _____
 Name of Physical/Occupational Therapist _____

MOBILITY EQUIPMENT

1. Describe the specific mobility equipment that is being requested:

2. Describe how the mobility equipment will assist your child:

3. Describe how the mobility equipment will assist the parent(s)/Guardian:

4. Who identified the need for this type of mobility equipment?

5. Is the child eligible for:	Will agency pay for the equipment requested?			
Private Insurance	YES	NO	YES	NO
Medicaid	YES	NO	YES	NO
APD (Agency for persons with Disability)/Development Services	YES	NO	YES	NO
Children's Medical Services	YES	NO	YES	NO
Vocational Rehabilitation (16 yrs. Or older)	YES	NO	YES	NO
Other: _____	YES	NO	YES	NO

If the agency will not pay for the mobility equipment please provide a letter of denial. (A letter of denial from Medicaid for a stroller is not necessary as we know Medicaid will not pay for a stroller.)

PARENT(S) / GUARDIAN:

I understand that WFK is a non-profit organization and by this application I am not guaranteed the mobility system requested.

I grant permission for WFK to take pictures of my child for fund raising purposes.

Parent /Guardian

Date