



PO Box 465
Itasca, IL 60143-0465
Phone: (630) 766-0505 x8

THE KIDS EQUIPMENT NETWORK APPLICATION

DATE: _____

REFERRAL SOURCE INFORMATION:

Name: _____
Agency: _____
Relationship to applicant: _____

Address: _____
Email: _____
Phone: _____

APPLICANT INFORMATION:

Child's name: _____
Date of Birth: _____ Age: _____
Phone: _____
Address: _____
City: _____
County: _____

Gender: Male / Female
Alternate phone: _____
Email address: _____
State: _____
Zip: _____

Diagnosis / Disabling condition: _____

Mother's name: _____

Father's name: _____

Health coverage: Private Insurance (Company): _____, Medicaid
 Medicaid Managed Care: _____ Other: _____, None

EQUIPMENT REQUEST:

Check box: Manual wheelchair: self-propel propelled by others tilt in space tie downs
 Power wheelchair: functions needed _____
 Adaptive stroller Walker: type _____ Gait trainer
 Crutches: type _____ Stander Bath/Shower chair Adaptive toilet system
 Specialized car seat Other: _____

Weight: _____ pounds Height: _____ inches

NOTE: For ambulatory aids (e.g. walker, crutches, gait trainer, etc.) please provide floor-to-wrist height while standing: _____ inches. Not applicable

NOTE: For seating devices (e.g. wheelchairs, etc.) please complete the sizing chart on page 2. Not applicable

Statement of how equipment will benefit child: _____

Has funding been previously requested: please list source(s): _____

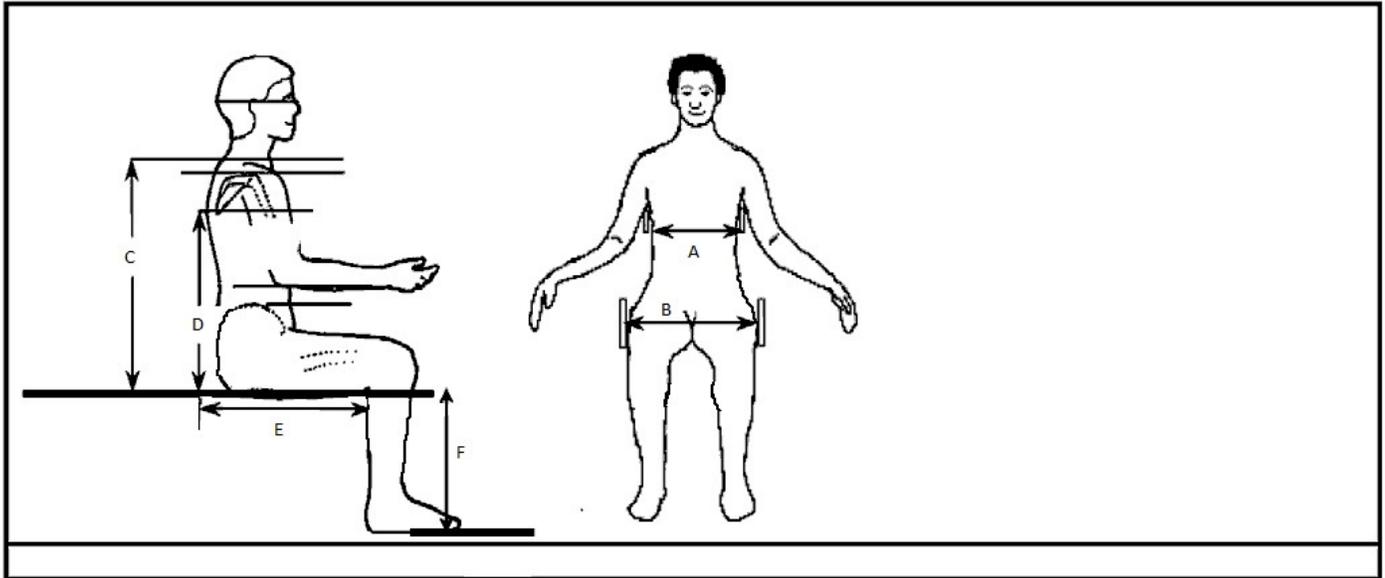
If yes, please provide the current status of your request (e.g. in review, denied): _____

If this was denied by funding, has it been appealed? yes date of appeal _____ no

Child's Name: _____

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MAT EVALUATION:



Please provide measurements in inches

A: Chest Width

B: Hip Width

C: Seat to Top of Shoulder

D: Seat to Inferior Angle of Scapula

E: Seat Depth

F: Lower Leg Length

Additional Comments: _____



Child's Name: _____

Version: 12-2015