

Application Instructions

The purpose of this document is for Kids Mobility Network, Inc. to learn more about the potential recipient (“Recipient”) of durable medical equipment (“DME”), which may be provided by Kids Mobility Network, Inc. The information provided in this application is important to properly assess the needs of Recipient and to establish a preliminary match between our Recipients and our inventory of DME. Please answer all questions thoroughly to provide us with the best information possible.

For consideration, please complete this application entirely. Along with the application, all applicants should include any of the following that are available and appropriate:

- A note from physician or medical professional confirming diagnosis and stating medical need for specific durable medical equipment
- A copy of insurance card or proof of Medicaid coverage and any denials for DME

Upon completion of the application please submit to Kids Mobility Network, Inc. via one of the following three methods (any method is acceptable):

- Email to applications@kidsmobility.org
- Fax to 1-866-449-8962
- or Mail to: Kids Mobility Network, Inc.
4251 S. Natches Court, Suite C
Sheridan, Colorado 80110

Kids Mobility Network asks each family to make a donation at the time they receive DME. Reconditioning DME is very expensive. Donations help Kids Mobility Network to sustain its operations to help families. Scholarships are available for families that are unable to make a donation. Please indicate if recipient is a scholarship candidate.

Suggested donations for DME to help with costs of storage, reconditioning & placement:

- Walker/Gait Trainer: \$150
- Stander: \$200
- Manual Wheelchair: \$200
- Miscellaneous DME: \$100
- Power Wheelchair: \$500 (plus cost of batteries)
- Adaptive Bike: \$150

For assistance with completing this application, please call Kids Mobility Network, Inc. at 303-242-8281.

IMPORTANT NOTE:

IT IS THE POLICY OF KIDS MOBILITY NETWORK, INC. TO STRICTLY MAINTAIN THE CONFIDENTIALITY AND SECURITY OF ALL PERSONAL AND MEDICAL INFORMATION. KIDS MOBILITY NETWORK WILL USE THE PERSONAL AND MEDICAL INFORMATION, WHICH HAS BEEN VOLUNTARILY PROVIDED IN THIS APPLICATION, ONLY TO ASSIST IN ACQUIRING REQUESTED PRODUCTS, SERVICES AND/OR BENEFITS. KIDS MOBILITY NETWORK WILL NOT SHARE NAMES OR OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION UNLESS IT IS NECESSARY TO ACQUIRE A REQUESTED PRODUCT, SERVICE OR BENEFIT.



PERSONAL INFORMATION FOR RECIPIENT

Date of Application: _____ Phone: (____) _____

Recipient's Name: _____ Male Female

Recipient's Address: _____

Recipient's City, State, Zip: _____

Recipient's County: _____ Do you speak English? Yes No

Recipient's Age: _____ Number of people living in Recipient's Home: _____

Social Security #: _____ - _____ - _____ Yearly Family Income*: \$ _____

** Kid's Mobility Network, Inc. may request written verification of income.*

Parents/Legal Guardians: _____

Relationship to Recipient: _____ Do you speak English? Yes No

Street Address: _____

City, State, Zip: _____

Phone: (____) _____ Email: _____

Phone2: (____) _____ Phone3: (____) _____

How did you hear of Kids Mobility Network? _____

Referring organization (if applicable): _____

Would you like to request a scholarship to assist with the suggested donation? Yes

Type of durable medical equipment requested:

Pediatric Walker Manual Wheelchair Tilt Wheelchair Power Wheelchair

Stander Adaptive Bike Other Equipment _____



INSURANCE, MEDICAL & EMPLOYMENT INFORMATION

Medical Insurance Carrier: _____

Street Address: _____

City, State, Zip: _____

Phone: (____)_____ Contact person: _____

Does Recipient have Medicaid coverage? Yes No Medicaid #: _____

Is there any other form of coverage? Yes No (If so complete below)

Other Coverage Provider: _____



Parent/Legal Guardian Employer: _____

Street Address: _____

City, State, Zip: _____

Phone: (____)_____ Contact person: _____



Primary Diagnosis: _____

Other Diagnoses: _____

Primary Care Physician: _____ Phone: (____)_____

Rehab Doctor: _____ Phone: (____)_____

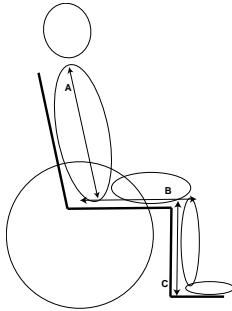
Orthopedic Doctor: _____ Phone: (____)_____

PT or OT Therapist: _____ Phone: (____)_____

Current Equipment Provider: ATG Rehab United Seating & Mobility Other

DURABLE MEDICAL EQUIPMENT QUESTIONNAIRE

The following information is designed to provide the necessary information required to properly fit Recipient with the appropriate equipment. Please complete to the best of your knowledge. If you have any questions, please contact us at 303-242-8281.



Please Provide the Following Measurements for Recipient:

- Recipient's Overall Height: _____
- Recipient's Weight: _____
- Width of Hips (from outside to outside)*: _____
- Trunk Height (A)**: _____
- Seat Depth (B)***: _____
- Lower Leg Length (C)****: _____
- Inseam: _____

* Width of Hips is the space between recipient's hips while seated. To measure, place a piece of cardboard on each side of recipient's hips and record the distance between them.

** Trunk height is measured from top of shoulder to bottom of butt while sitting.

*** Seat Depth is measured as the back of the knees to the lower back while sitting.

**** Lower Leg Length is measured from the bottom of the thigh to the bottom of the heel.

Does Recipient have trouble with any of the following:

- | | | | | | |
|----------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Tremors? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Head control? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vision loss or blurring? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hand numbness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of his/her right hand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Impaired judgment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of his/her left hand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pressure Sores? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Impaired trunk strength? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hand coordination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Compromised Circulation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Boney Prominence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Requires supports to sit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Incontinence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Can Recipient propel a manual wheelchair? Independently with difficulty No

Can Recipient operate a power joystick? Right hand Left hand Other method

Does Recipient need help with transfers (moving from place to place)? Yes No

If yes, does Recipient need help Sometimes or All or most of the time

Does Recipient have a caregiver? Yes No

Will Recipient be using the mobility device (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Inside a home or apartment? | <input type="checkbox"/> Outside a home or apartment? |
| <input type="checkbox"/> For travel? | <input type="checkbox"/> For work? |

Are there steps to enter the Recipient's Home? Yes No - If yes, how many? _____

Is there a ramp available at the Recipient's Home? Yes No

If no, does Recipient require a ramp? Yes No



Please list the width of the following doorways. To measure accurately, open the door to 90 degrees and measure from the face of the door to the doorstop.

Main entrance (front) _____ Main entrance (back) _____

Garage entrance _____ Bedroom door _____

Bathroom door _____

Does Recipient currently use any DME or assistive devices? Yes No

Type: _____ Brand/Model: _____

Type: _____ Brand/Model: _____

Type: _____ Brand/Model: _____

Does Recipient plan to transport the received DME in his/her vehicle? Yes No

If yes, what is the year, make, and model of the vehicle?

Year _____ Make _____ Model _____

If yes, will assistance be required in loading it? Yes No

Please explain assistance required: _____

Does Recipient plan to use accessible public transportation/school bus? Yes No

Please explain Recipient's DME status, goals, and any other important information:

Please feel free to provide additional information with this application if necessary.



DME TERMS AND CONDITIONS AGREEMENT FORM

By my signature below, I (Recipient or Parent/Legal Guardian for minors) acknowledge that I understand and agree:

1. That Kids Mobility Network, Inc. is not obligated to provide any or all of the DME that have been requested. Kids Mobility Network, Inc. retains the right to make the final determination on which equipment to distribute.
2. That some DME is restricted to size and weight, therefore Kids Mobility Network, Inc. is neither responsible nor liable for fitting the requested equipment to distribute.
3. That many of the pieces of DME provided by Kids Mobility Network is used and may have been reconditioned with parts and pieces not provided by the original equipment manufacturer.
4. That upon receipt of any DME, I will inspect the equipment and notify Kids Mobility Network, Inc. of any problems or damage that may have occurred prior to my receipt of the DME.
5. That I will release, hold harmless, and discharge Kids Mobility Network, Inc., its agents, officers, employees, affiliates, and all other persons, firms, associations and corporations of and from any and all actions, claims and demands which Recipient may now have, or may later have on account of injuries to Recipient or damages to any property arising out of an accident, casualty or occurrence which may happen through the use of misuse of DME provided by Kids Mobility Network, Inc.
6. That the DME upon delivery to Recipient will become the sole responsibility of Recipient, and that all maintenance, repairs and replacements (such as batteries) are the sole responsibility of Recipient.
7. That the personal and medical information that I have voluntarily provided to Kids Mobility Network, Inc. may be used or shared for the sole purpose of acquiring the product, service or benefit I have requested. I understand Kids Mobility Network's policy is to strictly maintain the confidentiality and security of all personal information.
8. I have read, understood and agreed with each of the terms and descriptions as stated above.

Recipient's Parent or Legal Guardian

Signature: _____ Date: _____

Printed Name: _____