Children's Mobility Partners

Assistance Request Form **Date:**

PATIENT INFORMATION	
Patient Name:	DOB:
Diagnosis:	
Functional Impact of Diagnosis (please explain):	
Clinical Goals:	
Patient/Parent Goals:	

PARENT INFORMATION	
Parent/Guardian Name:	
Address:	
Phone:	Email:

MEDICAL EQUIPMENT/INTERVENTION DETAILS

ORTHOTIC NEEDS (AFO's, TLSO's, and other braces):	**THERAPY EQUIPMENT NEEDS:**
☐ 1:_____	☐ 1: _____
☐ 2:_____	☐ 2: _____
☐ 3:_____	☐ 3: _____
☐ 4:_____	☐ 4: _____
Cost of equipment: $ _____	**Cost of equipment: $ _____**
Agreed Copayment: $_____	**Agreed Copayment: $_____**
*Please include invoice or order details	*Please include invoice or order details

TOTAL COST OF EQUIPMENT: $ _____ TOTAL COPAYMENT: $_____ TOTAL REQUEST:_____

ASSISTANCE RATIONALE

- ☐ Currently unemployed
- ☐ No health insurance
- ☐ High Medical Expenses (deductibles)
- ☐ Low or fixed income
- ☐ Student
- ☐ Other :_____

PROVIDER & RELEASE OF LIABILITY

Provider of equipment:

Were instructions given? ☐ Yes ☐ No If no, explain:

I aknowledge that Children's Mobility Partners (CMP) is only assisting with the cost of the equipment. I agree that any equipment failure and or malfunction is the responsibilty of the manufacturer of the equipment and the clinical provider.

Parent/Guardian Signature: _____ Date:_____

Provider Signature: _____ Date: _____