# Special Needs Equipment Fund Application

***Please read the Special Needs Equipment Fund Guidelines before completing this application.***

***All sections of this application must be completed.***

Name of Client: ______________________________________________ Sex: _____ Age: _______

School: __________________________________________________________ Grade: _____________

Date of Birth: ________________

Disability and/or diagnosis: ______________________________________________________________

Method of Mobility: _____________________________________________________________________

Method of Communication: _______________________________________________________________

Race/Ethnicity

- ☐ White non-Hispanic
- ☐ Black non-Hispanic
- ☐ Haitian (of any race)
- ☐ Hispanic (of any race)
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Multiracial/Multiethnic (two or more races or ethnicities)
- ☐ Other
- ☐ Unknown

Parent(s)/Guardian Name: _______________________________________________________________

Address: ______________________________________________________________________________

Zip Code: ______________ Phone: __________________________

E-mail address: __________________________

Household Income (reference attached table):

- ☐ At or below 100% of the Federal Poverty Level
- ☐ 101% of the Federal Poverty Level
- ☐ Above 225% of the Federal Poverty Level
- ☐ Unknown

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Referring Therapist: ______________________________

Agency: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

E-mail Address: ______________________________

1. **Equipment Requested**

a) Describe the specific equipment that is being requested/recommended: ____________________

______________________________

b) Describe how this equipment will assist the child: ____________________

______________________________

c) Has the child tried this equipment? If not, why?: ____________________

______________________________

d) Who identified the need for this equipment?: ____________________

e) Approximately how long will the equipment be used?: ____________________

**2. Clinics Can Help**

a) Has Clinics Can Help (561-640-2995) been contacted to see if the requested equipment is available free of charge? ☐ Yes ☐ No

b) Has the child received equipment from the Special Needs Equipment Fund in the past? ☐Yes ☐No

- If yes, please give an approximate date the equipment was received and brief description of the equipment: ____________________

- Was the equipment donated to a lending closet, such as Clinics Can Help, after use?
☐ Yes ☐ No

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**3. Insurance (please circle all that apply)**

| 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 Disabilities) Medicaid Waiver | Yes | No | Yes | No |
| Children's Medical Services | Yes | No | Yes | No |
| Vocational Rehabilitation | Yes | No | Yes | No |
| School District (Hearing Aids) | Yes | No | Yes | No |
| Other: __________________ | Yes | No | Yes | No |

If the child has any of the medical payor sources listed above, but the agency will not fund the equipment requested, please include an explanation below. **A letter of denial from the declining agency (e.g., Medicaid, private insurer) must be submitted for most items (see Application Guidelines).**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The Special Needs Equipment Fund is the payor of last resort. A contribution from the child's family is recommended to offset the cost of the equipment. A statement from the family indicating the amount to be contributed or indicating a hardship that prevents them from contributing will be included with this application. Family contributions will be in the form of a donation to United Way's Special Needs Equipment Fund.

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**4. Vendor Quotes**

Please attach **two price quotes** for each item requested (unless the items require custom measurements). If two price quotes are not included (see Guidelines for exceptions), please explain vendor preference below.

| Vendor/Manufacturer Name | Price Quote | Shipping Cost | Total Cost |
|---|---|---|---|
| 1. ______________________ | $__________ | $__________ | $______________ |
| 2. ______________________ | $__________ | $__________ | $______________ |

Does this equipment come with a warranty? ☐ Yes ☐ No

If yes, what is the cost? $____________

Indicate vendor/manufacturer preference and explain. If requested vendor price is higher than others, specify why the less expensive model will not meet the needs of the child:

______________________________________________________________________________

______________________________________________________________________________

Total cost of the equipment requested (including warranty and shipping): $ ______________

Amount to be paid by the insurer: - $ ______________

Amount to be paid by civic, religious, or community organizations: - $ ______________

Amount of family's contribution (if any): - $ ______________

Total Amount to be paid by the Special Needs Equipment Fund: $ ______________

In the event the purchase price of the requested equipment exceeds the amount of the Equipment Fund cap, please refer to the Guidelines.

**NOTE: United Way of Palm Beach County's Special Needs Equipment Fund awards are always paid out in full to chosen vendor. Please review the Guidelines for proof of purchase policy.**

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## 5. Attachments

Please attach the following items to this application:

- ☐ Two vendor/manufacturer price quotes for the exact cost of the equipment requested (please see Guidelines for exceptions)
- ☐ A letter of medical necessity from a licensed/certified provider who is knowledgeable of the child's condition
- ☐ Medicaid or insurance denial letter (please see Guidelines for exceptions)
- ☐ Photo of the equipment

## 6. Acknowledgement and Authorization

By signing this application, the submitting therapist and the applicant's family declare that the family is in need, has no other means to obtain the equipment, and will authorize release of any information contained herein to United Way of Palm Beach County to substantiate the request.

The submitting therapist and the applicant's family further declare that the equipment purchased will be used for the sole purpose for which it has been requested. Any misuse of equipment is not acceptable and will be brought to the attention of the appropriate parties.

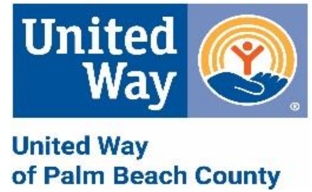
The applicant's family agrees that, to the best of its ability, it will seek to donate the equipment to Clinics Can Help once it is no longer being used.

Finally, the family agrees that Clinics Can Help may call periodically to inquire as to whether the equipment is still being used.

**I understand that approval of this request rests with the Special Needs Equipment Fund Committee and the board of directors at United Way of Palm Beach County.**

______________________________________ ____________________
Signature of Referring Therapist Date

______________________________________ ____________________
Signature of Parent or Guardian Date




Please direct all questions and inquiries to Shayene Weatherspoon, Director of Community Impact via email shayeneweatherspoon@unitedwaypbc.org or telephone (561) 375-6639.

Completed applications and required attachments can be submitted to the email address above or sent via U.S. postal mail:

United Way of Palm Beach County
Special Needs Equipment Fund c/o Shayene Weatherspoon
477 S. Rosemary Avenue, Suite 230
West Palm Beach, FL 33401

# U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

## FEDERAL POVERTY GUIDELINES FOR 2020

The 2020 poverty guidelines are in effect as of January 15, 2020.

The Federal Register notice for the 2020 Poverty Guidelines was published January 17, 2020.

| 2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | |
|---|---|
| PERSONS IN FAMILY/HOUSEHOLD | POVERTY GUIDELINE |
| For families/households with more than 8 persons, add $4,480 for each additional person. | |
| 1 | $12,760 |
| 2 | $17,240 |
| 3 | $21,720 |
| 4 | $26,200 |
| 5 | $30,680 |
| 6 | $35,160 |
| 7 | $39,640 |
| 8 | $44,120 |