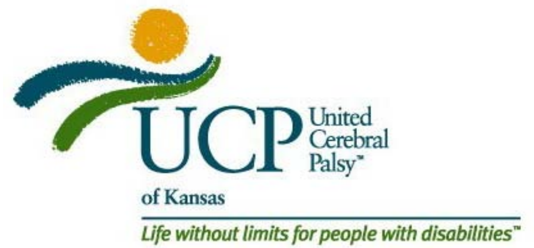
UNITED CEREBRAL PALSY OF KANSAS
Application for Financial Assistance



Client's Name ____________________ Age _____ Date of Birth ____________ Sex Male ☐ Female ☐
Address ________________________ City ____________ County ____________ State ________
Zip Code ____________ Phone (   ) ______________ E-mail Address ______________________

Parent's Name(s) (if client is a minor) ____
Father's Place of Employment ________________ Mother's Place of Employment ________________
Client's Place of Employment ____

Disability or Diagnosis ____
Date of onset of disability (at birth) ______________ (other) __________________
Equipment requested ____
Total Cost $____________ Amount family can contribute toward cost $____________
Amount requested from UCP $____________

Have any other agencies or groups been contacted for assistance? Yes ☐ No ☐
If yes, which agencies and what was the outcome _____________________________________
____

Will your personal insurance cover any or all of the equipment requested? Yes ☐ No ☐
If yes, how much? ____________ Name of the Insurance Company ________________________

Is client eligible for and/or receiving assistance from: (check one)

Health Wave	Yes ☐	No ☐	Supplemental Security Income (SSI or SSDI)	Yes ☐	No ☐
Social Security	Yes ☐	No ☐	Kansas Special Health Care Needs	Yes ☐	No ☐
Medicaid (KanCare)	Yes ☐	No ☐	Medicare	Yes ☐	No ☐

Do you have a prescription or professional recommendation for the item requested? Yes ☐ No ☐
If yes, from whom? ____
Gross annual family income $ ____________ Number of persons living in the household __________

I verify that the information provided above is accurate and I agree to complete a follow-up questionnaire if provided with financial assistance.

Signature ____ Date __________________

Please return to:

UCP of Kansas
P.O. Box 8217
Wichita, KS 67208
FAX (316) 688-5687
davej@ucpks.org