CUYAHOGA COUNTY Board of Developmental Disabilities

NEON COUNCIL OF GOVERNMENTS

Family Support Equipment Request Form

Client Name: _____ Date Assessed: _____
Family Name: _____ Phone: _____
Address: _____ D.O.B. _____
City: _____ Zip: _____
Doctor: _____ Dx: _____

All information must be filled out, or this form will be returned to the therapist requesting special equipment.

Equipment Requested: *(Please attach vendor picture, description, cost, name and address. Each vendor must have a separate form filled out.)*

_____
_____
_____
_____

A. Equipment Rationale:

1. Purpose of this equipment? _____
   _____
   _____

2. Does the client have equipment like this?
   _____

3. What kind of equipment does the client currently use? _____
   _____
   _____

4. Has the client been assessed with this type of equipment previous to this request? _____
   _____
   If the answer is no, how do you know it will work? _____
   _____
   _____

   *****If not assessed, priority will go to those who have been*****

5. Description of child/adult: Weight _____Height _____
   Overall Length _____ Calf Length _____ Thigh Length _____
   Hip Width _____

   What is the growth potential of the child and this piece of equipment? _____
   _____
   _____

6. How will the client best benefit from this equipment? _____
_____
_____

a) Who will set up and adjust the new equipment in the home? _____
_____

b) Who will train the family the correct way to use the new equipment? _____
_____

c) Who will follow up usage of this equipment? _____
_____

d) Expected number of visits to be made for set-up and follow-up? _____
_____

7. Is there adequate space in the home to use this equipment? _____
*Describe the home/apt. usable space… _____
_____

B. Functional Abilities:

1. Describe the client's cognitive/motivation level _____
_____
_____

2. Describe the client's highest functional gross motor level _____
_____
_____

3. How does the client's ROM limitations affect the use of this piece of equipment? _____
_____
_____

C. Wheelchair Information:

1. How will the wheelchair be transported? _____
_____

2. What kind of home does the client live in? (apt/house/one-floor/stairway?) _____
_____

3. Is the living arrangement wheelchair accessible? _____

4. What is the client's ability and safety level in propelling the wheelchair? _____
_____
_____

D. Strollers:

1. What type of equipment is now being used for transportation? _____
   _____
   _____

2. How will the stroller be used? _____
   _____

******FAMILY SIGNATURE******

I am aware and in agreement with the item(s) recommended by the therapist.

_____ _____
signature date

*This equipment belongs to the child/family it is purchased for. Family/individual is responsible for its upkeep.

Equipment that you can no longer use can be donated back to the Family Support Program. Please call Dave Hirchak, Equipment Manager (216) 761-7624 or hirchak.david@cuyahogabdd.org.

Equipment to Be Delivered to:

Name: _____
Address: _____
City, Zip: _____
Phone Number: _____

I have verified that the above equipment cannot be funded through Medicaid, Medicare, private insurance, another funding source OR the request has been denied by the Ohio Department of Medicaid. If there is a denial letter, attach to this form. _____ (Initials of Therapist)

_____ _____
Signature of Therapist Agency

_____ _____
Therapist – **Please Print** Address of Agency

Daytime phone number _____ _____
City Zip

E-Mail Address _____
Notify therapist that family has received equipment: _____yes _____no

Please Return This Form to:

North East Ohio Network
Attn: Cuyahoga Family Support Program
5121 Mahoning Avenue
Austintown, OH 44515

Phone: (800) 237-6828 Fax: (855) 336-6968 (Toll Free) email address: CuyFSS@neoncog.org

9/9/15