



# KAITLIN'S MOBILITY FOUNDATION

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P.O. Box 2245, Everett, WA 98213 / (425) 870-8386 / [www.kaitlinsfoundation.org](http://www.kaitlinsfoundation.org)

## GENERAL INFORMATION

The objective of Kaitlin's Mobility Foundation is to provide funds and resources for families with special needs children ages 18 and under, with a purpose to offset the cost of mobility equipment that is medically and/or conveniently necessary. Funds will be distributed on a non-discriminatory basis regardless of sex, race, religion, economic status, income level, or family size. It is recognized that mobility equipment designed specifically for disabled children is expensive, and that individual families may not reasonably have available financial assistance from which to offset the tremendous cost of such equipment. Therefore, Kaitlin's Mobility Foundation is established to assist families through all phases of their child's life in support of providing equipment that is beneficial and/or convenient to their quality of life.

## GRANT PROGRAM

Kaitlin's Mobility Foundation grant applications may be used for modest awards for assistive devices, medically necessary equipment, mobility equipment, lifts, ramps, therapeutic horseback riding, etc. for disabled children ages 0-18 who live in the State of Washington, USA. Applications may be submitted by families (parent or guardian) for an individual child. Applicants should not submit more than one application per year, and KMF reserves the right to reject any request. Applications will be reviewed throughout the year, and funds will be distributed accordingly.

**Upon approval of a grant application, a check will be made payable to a company that specializes in assistive devices.** Checks will not be made payable to the applicant.

KMF is not liable for warranty claims, or any damages to property or persons that are incurred due to manufacturing defect or personal use. Equipment or property becomes the responsibility and sole ownership of the applicant. Kaitlin's Mobility Foundation grants are between \$25-\$500.

## APPLICATION INSTRUCTIONS

**Please fill out the application completely. Incomplete applications will not be reviewed.** Be sure to have your physician or health care professional's written signature on this application. Applications must be legible or typewritten (if possible).

Mail signed application to: Kaitlin's Mobility Foundation, P.O. Box 2245, Everett, WA 98213. Grant applications will be reviewed annually on February 28, May 31, and September 30.

# KAITLIN'S MOBILITY FOUNDATION GRANT APPLICATION

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## A. Parent(s)/Legal Guardian(s) Information

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number Email

## B. Child Information

\_\_\_\_\_  
Last Name First Name MI

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Age: \_\_\_\_\_

Child's Condition/Diagnosis: \_\_\_\_\_

Has the child named in this application received a grant from KMF before?  NO  YES  
If yes, please indicate the equipment and year the grant was received. A family may receive one grant/year.

## C. Physician/Health Care Professional Information

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Institution/Organization/Office/Agency

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number Email

**D. Equipment Information**

Type of equipment to purchase: \_\_\_\_\_

Manufacturer: \_\_\_\_\_

Model Number: \_\_\_\_\_

Total Cost: \$\_\_\_\_\_. Grants are from \$25 to \$500. One item per application.

Amount requested from KMF: \$\_\_\_\_\_. Checks are payable to the equipment provider only.

**E. Equipment Provider Information**

If the application is approved, make the check from KMF payable to:

\_\_\_\_\_  
Institution/Organization/Office/Agency

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number Email

**F. Signatures of Parent/Legal Guardian and Physician/Health Care Professional**

I certify that the information provided to Kaitlin's Mobility Foundation is true and correct to the best of my knowledge. I agree that Kaitlin's Mobility Foundation is not liable for warranty claims, or any damages to property or persons that are incurred due to manufacturing defect or personal use. I further agree that equipment or property becomes the responsibility and sole ownership of the applicant.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Date

\_\_\_\_\_  
Signature of Physician/Health Care Professional Date

FOUNDATION USE ONLY	
DATE RECEIVED: ____/____/____	REVIEWED BY: _____
DATE SUBMITTED: ____/____/____	NOTES: _____
APPROVED: YES _____ NO _____	DATE APPROVED: ____/____/____
AMOUNT GRANTED: \$ _____	APPROVED BY: _____