KAITLIN'S MOBILITY FOUNDATION

P.O. Box 2245, Everett, WA 98213 / (425) 870-8386 / 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 assitive devices, medically necessary equipment, mobility equipment, lifts, ramps, therapeutic horseback riding, etc. for disabled children ages 0-18. 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: _____