The Dake Foundation for Children Application for Adaptive Equipment and Services
PO Box 3575, Saratoga Springs NY 12866
dakefoundationforkids@gmail.com
(518) 226-0252

This application may be used for requests of equipment and services that have been denied by insurance and/or Medicaid. The foundation does not grant reimbursements. Depending on the grant, the Foundation reserves the right to request additional information. A complete application and all necessary attachments are required prior to board review.

1. Contact Information

Applicant Demographics:

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip:_____ County: _____

Telephone: (_____) _____ Email: _____

HCBS Waiver Enrolled: ☐ Yes ☐ No Utilizing Self Directed Services: ☐ Yes ☐ No

Representative Demographics:

Name: _____ Relationship to applicant: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Telephone: (_____) _____ Email: _____

Is the applicant your dependent: ☐ Yes ☐ No

2. Statement of Need/Grant Request

Please describe in detail the equipment/services you are requesting. Be sure the request is detailed and complete, please attach additional pages if necessary.

_____
_____
_____
_____

3. Statement of Medical Justification

Please attach a letter(s) of medical justification outlining the need of the equipment/service requested from a qualified medical professional (Physical Therapist, Pediatrician, Speech Pathologist, Occupational Therapist, or specialist).

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4. Statement of Personal Finances

Please indicate which statement represents your ability to contribute financially towards the requested items.

☐ I/we are unable to contribute to the purchase of the requested items as it would cause a financial hardship on our family.

☐ I/we are able to contribute towards the purchase of the items. Contribution: _____

5. General Information

Equipment/Service Requested:

_____
_____
_____

Website or Flyer: _____

Expected Cost: _____

Has the child had previous positive experiences and/or exposure to equipment/services like this request?

_____
_____
_____

Is the applicant receiving therapy services at this time (PT/OT/Speech): ☐ Yes ☐ No

Therapy Received: _____

Therapist: _____ Email: _____

Introduce us to the applicant and their current level of independence (if possible, please include the current Life Plan):

_____
_____
_____
_____

Explain how the equipment/service requested would support the child towards further independence and fun.

_____
_____
_____
_____

I declare the information presented in this application is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____