



Variety of Colorado - The Children's Charity
10497 Centennial Road
Littleton, Colorado 80127-4218
Tel 303-962-1184 Fax 303-973-8884
Email: info@varietycolorado.org
Website: www.varietycolorado.org

Miracles in Motion Applicant Information Packet

Thank you for your interest in Variety of Colorado's **Miracles in Motion** Program.

Variety is an international non-profit organization founded in Pittsburgh in 1928 to serve children. Over the years, Variety has evolved to meet the unmet needs of children within our ever changing communities.

Variety of Colorado – The Children's Charity's **Miracles in Motion** Program provides equipment to enable children to participate in their communities. Variety of Colorado helps children with disabilities, 21 years of age and younger by providing enabling equipment (wheelchairs, van lifts, house ramps, adaptive car seats & strollers, specially-equipped tricycles & bicycles, stair lifts and other items) and assistive technology and communication devices, when this equipment cannot be obtained from any other source.

Please read through the enclosed material and completely fill out the application packet. Once a packet is completed (a checklist is included with this packet), return the material in its entirety to the address listed above. It is imperative that only completed applications be submitted. The **Miracles in Motion** Program Committee will only review completed applications for determination.

NOTE TO APPLICANT:

- You must submit equipment specifications for your application to be considered. Your child's physical therapist, durable medical equipment supplier, educational specialists or pediatrician can assist you in securing this information.
- Remember to include denial letters, or partial support letters, from insurance companies, other community groups, etc. Variety is a funder of last resort, which means that other avenues of support must have been attempted before Variety can fund your request.
- Please review and sign the verification of information, Release of Liability and Disclaimer. We cannot release any equipment without these forms.
- Review the Authorization to Use Name and Likeness Release. This release is optional. Please note: applications will not be given favorable or unfavorable consideration based upon this release. However, please remember that your willingness to assist Variety in its public relations efforts will help us in procuring further support for this, and other, Variety programs.

Again, we thank you for your interest in the **Miracles in Motion** Program. We look forward to the possibility of working with your family. If you have any questions about this program, the application process or any other Variety program, please feel free to contact us directly.

Sincerely,

Shirley S. Patenaude
Executive Director



Miracles in Motion Program Application Checklist

Please note that this form does not need to be returned to Variety.
It is for your use in filling out the application form itself.

TO COMPLETE YOUR APPLICATION, THE FOLLOWING INFORMATION IS NEEDED – PLEASE SEND AS ONE PACKET:

- _____ Letter(s) of verification from professionals you identified (therapist, doctor, social worker) who are most familiar with your child's needs. This letter should specify your child's needs for the equipment requested.
- _____ A prescription from the child's doctor.
- _____ Copies of denial letters from Insurance Companies/Medicaid.
- _____ Copies of determinations from relevant insurance programs.
- _____ Copies of federal income tax returns for last three (3) years, pages 1 & 2, with Social Security number(s) blacked out.
- _____ Clear, detailed description of equipment to meet child's needs.
- _____ Equipment bids (one to three) from suppliers (*Variety can assist you in choosing a vendor*).
- _____ Completed Application Document.
- _____ Health Care Professional Contact Sheet with Signatures.
- _____ Disclaimer with Signatures.
- _____ Release of Liability with Signatures.
- _____ Authorization to Use Name & Likeness (signature optional).
- _____ Recent Photo of Child.
- _____ Signatures of all legal guardians & complete demographic data.
- _____ Any Supplemental Attachments or Additional Information.

If funding is approved, we do require photographs of child with equipment (preferably within a month of project completion). Please use 35mm film or you can submit a digital image via email to info@varietycolorado.org.

Please mail, fax or email completed application to:

Variety of Colorado
10497 Centennial Road
Littleton, CO 80127-4218
Email: info@varietycolorado.org
303-962-1184 Fax: 303-973-8884



Miracles in Motion Program Application Document

Mission Statement

Variety of Colorado – The Children’s Charity’s **Miracles in Motion** Program provides equipment to enable children to participate in their communities. Variety of Colorado helps children with disabilities, 21 years of age and younger, by providing enabling equipment (wheelchairs, van lifts, house ramps, adaptive car seats and strollers, specially-equipped bicycles and tricycles, stairlifts and other items) and assistive technology and communication devices, when this equipment cannot be obtained from any other source.

Instructions

- Please type or print in black ink.
- Review contents of completed application in the introductory letter.
- Fully complete all sections and forms of the application.
- Attach additional sheets where necessary.
- Original applications must be received prior to any final determination.
- For assistance, please contact 303-962-1184.
- The **Miracles in Motion** Program Committee reviews this information.
- Please mail, fax or email completed application with supporting documents to:

Variety of Colorado
10497 Centennial Road
Littleton, CO 80127-4218
Email: info@varietycolorado.org
Fax: 303-973-8884

Date of Application: _____ Received by Variety: _____

Applicant Information:

Child’s Name: _____ Gender: _____ M _____ F

Current Age: _____ Date of Birth (m/d/yy): _____ Child speak English: _____ Y _____ N

Number of Siblings, if any: _____ Own Home: _____ Yes _____ No

Address Where Child Resides: _____

City, State and Zip: _____

County of Residence: _____

Phone Number: Home _____ Work _____ Cell _____

Father’s occupation and place of employment: _____

_____ Father speaks English: _____ Y _____ N

Mother’s occupation and place of employment: _____

_____ Mother speaks English: _____ Y _____ N

Medical Information:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Is applicant currently participating in (check all that apply): _____ PT _____ OT

Request:

Type of Equipment: _____

Requested Funding from Variety: \$ _____

If Variety is unable, for whatever reason, to fulfill the entire request, is partial funding an option? _____ Yes _____ No

Please provide a brief description of the child's situation and of the benefit the requested equipment will provide. Please indicate the family's ability and willingness to participate financially in the purchase.

Insurance Information:

Does the applicant have medical insurance? _____ Yes _____ No

Does the applicant have Medicaid or Waiver? _____ Yes _____ No

If yes: Name of Provider: _____

Policy Number: _____

Name of Insured: _____

Is request: Partially Covered by Provider _____

Uncovered by Provider _____

Unsure of Coverage _____

If partially covered, what amount is not covered (rounded): \$ _____

Household Income (adjusted gross income) and Uncovered Medical Expenses

20 _____ \$ _____ Uncovered Medical Expenses \$ _____

20 _____ \$ _____ Uncovered Medical Expenses \$ _____

20 _____ \$ _____ Uncovered Medical Expenses \$ _____

Potential Funding Sources

Please fill out the following funding resource checklist completely. This checklist documents your efforts to secure funding for the needed equipment through other sources such as insurance, Office of Vocational Rehabilitation, etc. Please indicate whether you have sought funding from the following sources, and the outcome of your efforts.

Have Applied	Have Not Applied	NA	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>OFFICE OF VOCATIONAL REHABILITATION</u> — usually ages 18 and up; if younger, family should first request equipment from school system. Will fund post-secondary education, and purchase ramps, lifts, wheelchairs, prostheses and assistive devices. Vocational goal needed, but some “independent living funds” available. Will not fund orthopedic shoes unless attached to braces. (If you have applied, please describe outcome. If you have received a written denial, please attach a copy.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>MEDICAL ASSISTANCE (MEDICAID or WAIVER)</u> – consumer must get Rx from doctor and then submit form (30 - 40 day delay). If denied, appeal using MA-97. Authorizations may be held for 180 days. MA will fund manual wheelchairs. (If you have applied, please describe outcome. If you have received a written denial, please attach a copy.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEALTH INSURANCE</u> – check specific policy coverage. (If you have applied, please describe outcome. If you have received a written denial, please attach a copy.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>SCHOOL DISTRICT</u> – the child’s school district may provide certain equipment. (If you have applied, please describe outcome. If you have received a written denial, please attach a copy.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>OTHER</u> – please identify source and result

Other Funding

Has applicant requested support for this, or other items, from sources other than Insurance provider and Variety? _____ Yes _____ No

If yes, please provide the following information:

Agency	Nature of Request	Date of Request	Amount Requested	Amount Received	If denied, please state reason.

Are any of the sources previously stated pending for the items listed in this application?

_____ Yes _____ No

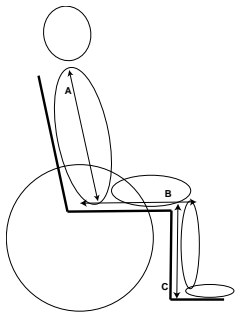
Prior Variety Determinations

Has the applicant, or his/her family, applied for assistance from any recognized entity within Variety in the past three years? _____ Yes _____ No

If yes, please explain: _____

Knowledge of Program

In an effort to thank your supporters and partners, please state how you first became aware of **Miracles in Motion** Program. _____



Please Provide the Following Measurements for Recipient:

- Recipient's Overall Height: _____
- Recipient's Weight: _____
- Width of Hips (from outside to outside)*: _____
- Trunk Height (A)**: _____
- Seat Depth (B)***: _____
- Lower Leg Length (C)****: _____
- Inseam: _____

* *Width of Hips is the space between recipient's hips while seated. To measure, place a piece of cardboard on each side of recipient's hips and record the distance between them.*

** *Trunk height is measured from top of shoulder to bottom of butt while sitting.*

*** *Seat Depth is measured as the back of the knees to the lower back while sitting.*

**** *Lower Leg Length is measured from the bottom of the thigh to the bottom of the heel.*

Does Recipient have trouble with any of the following:

- | | | | | | |
|----------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Tremors? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Head control? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vision loss or blurring? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hand numbness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of his/her right hand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Impaired judgment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use of his/her left hand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pressure Sores? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Impaired trunk strength? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hand coordination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Compromised Circulation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Boney Prominence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Posture abnormality? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Incontinence? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Can Recipient propel a manual wheelchair? Independently with difficulty No

Can Recipient operate a power joystick? Right hand Left hand Other method

Does Recipient need help with transfers (moving from place to place)? Yes No

If yes, does Recipient need help Sometimes or All or most of the time

Does Recipient have a caregiver? Yes No

Will Recipient be using the mobility device (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Inside a home or apartment? | <input type="checkbox"/> Outside a home or apartment? |
| <input type="checkbox"/> For travel? | <input type="checkbox"/> For work? |

Are there steps to enter the Recipient's Home? Yes No - If yes, how many? _____

Is there a ramp available at the Recipient's Home? Yes No

If no, does Recipient require a ramp? Yes No

Please list the width of the following doorways. To measure accurately, open the door to 90 degrees and measure from the face of the door to the doorstep.

Main entrance (front) _____ Main entrance (back) _____

Garage entrance _____ Bedroom door _____

Bathroom door _____

Does Recipient currently use any DME or assistive devices? Yes No

Type: _____ Brand/Model: _____

Type: _____ Brand/Model: _____

Type: _____ Brand/Model: _____

Does Recipient plan to transport the received DME in his/her vehicle? Yes No

If yes, what is the year, make, and model of the vehicle?

Year _____ Make _____ Model _____

If yes, will assistance be required in loading it? Yes No

Please explain assistance required: _____

Does Recipient plan to use accessible public transportation/school bus? Yes No

Supplemental Information

Please provide any additional information that might clarify your child's needs for enabling equipment and the family's inability to obtain these items. (Attach additional sheets where necessary.)

Name of Person Completing Application: _____

Speak English: ___ Y ___ N Relation to Child: _____

Address: _____

City, State and Zip: _____

County of Residence: _____

Phone Number: Home _____ Work _____ Cell _____



Miracles in Motion Program Health Care Professional Contact Sheet

Please list the names of two health care professionals who have worked with the child and can verify the need for the requested equipment. We will not contact these individuals without your authorization. If you consent at this time to allow Variety to contact the names below, please sign the bottom of this form.

Primary Pediatrician (Preferred)

Name: _____

Office Name: _____

Office Phone: _____

Length of Service to Applicant: _____

Pediatric Rehabilitation Specialists

Name: _____

Office Name: _____

Office Phone: _____

Length of Service to Applicant: _____

Physical Therapist/Occupational Therapist (circle one)

Name: _____

Office Name: _____

Office Phone: _____

Length of Service to Applicant: _____

Other: _____

Name: _____

Office Name: _____

Office Phone: _____

Length of Service to Applicant: _____

Legal Guardian Signature

Legal Guardian Signature



Miracles in Motion Program Disclaimer

The mission of Variety is to help purchase enabling equipment (wheelchairs, van lifts, house ramps, adaptive car seats and strollers, specially –equipped bicycles and tricycles, stairlifts and other items) and assistive technology and communication devices for children, 21 years and younger. The equipment we provide carries no warranty from Variety and its use, even in the event of malfunction resulting in injury, gives rise to no liability on the part of Variety. Variety is merely a funding source. Variety is in no way responsible for reclaiming, disposing of, maintaining or repairing equipment. It is the sole responsibility of the Recipient's legal guardian(s) to maintain, repair and/or dispose of the equipment. Any other costs that may be associated with the equipment such as installation, delivery, labor, disposal, etc., that are not explicitly stated on the application are the sole responsibility of the Recipient's legal guardian(s). All installations of ramps, lifts, stair glides, electrical supplies, etc., must be in compliance with applicable building codes. Variety is in no way responsible for ensuring compliance with any codes.

Before disbursement of any funds to purchase equipment, the legal guardian(s) of the Recipient must have this form signed, witnessed by a non-family member, and returned to Variety.

I, _____ (Legal Guardian's Name) _____ (Legal Guardian's Signature)

am the Legal Guardian of _____ (Recipient's Name Printed)

I have read and fully understand and agree to the above Disclaimer.

I, _____ (Legal Guardian's Name) _____ (Legal Guardian's Signature)

am the Legal Guardian of _____ (Recipient's Name Printed)

I have read and fully understand and agree to the above Disclaimer.

This document has been witnessed by

_____ on this date _____
(Name) (Date Signed)



Miracles in Motion Program Personal Likeness Release and Authorization Form

The Recipient and his/her parent(s) or legal guardian(s) hereby acknowledge and agree that acceptance of the resources from Variety of Colorado may result in publicity.

The Recipient and his/her parent(s) or legal guardian(s) hereby irrevocably authorize Variety of Colorado, Variety Clubs International, their members, employees and officers (hereafter collectively referred to as "Variety"):

- A. to publicize and use the Recipient's likeness, voice and features, with or without his/her name, for any publication, promotion, trade or business use, or any other purpose;
- B. to photograph, videotape, film and/or record Recipient in any manner Variety deems appropriate;
- C. to copyright, convey or otherwise distribute, now or in the future, any such material involving the Recipient, his/her parent(s) or legal guardian(s) and that said material may be distributed to anyone, for any purpose, including the general public, magazines, newspapers, television, radio stations and others;
- D. to publicize, now or in the future, the name of the Recipient including information regarding his/her physical condition and details regarding the resources received with the assistance of Variety.

The Recipient and his/her parent(s) or legal guardian(s) agrees that it is not necessary for Variety or anyone else to contact them prior to releasing any information authorized by this document. The Recipient and his/her parent(s) or legal guardian(s) hereby releases Variety from and against any and all claims, of any type, which arise from or are related to Variety's use, distribution or disclosure of any photographs, films, videotapes, electronic recording or other information regarding the Recipient and the award from Variety.

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

(Please note that your signature is not required on this form for the application to be considered by Variety – The Children's Charity. **However, we do require photos of your child with their awarded equipment.** Please note that we will only publish photos of children authorized by families signing this release form. Other photos will be kept confidential. However, these photos enhance our fundraising efforts to secure additional funding from corporate sponsors, individuals, and community foundations to help children with disabilities and to continue our programs. The use of personal stories increases Variety's chances of being successful in the endeavors. Thank you.)

IMPORTANT NOTE:

Variety of Colorado will strictly maintain the confidentiality and security of all personal and medical information. Variety of Colorado will use the personal and medical information, which has been voluntarily provided in this application, only to assist in acquiring requested products, services and/or benefits. Variety of Colorado will not share names or other individually identifiable health information unless it is necessary to acquire a requested product, service or benefit.