unlocked

Unlocking the potential of special kids with special abilities

Please send completed application, along with the following documents to info@unlockedinc.org:

1. A letter of medical necessity (LMN) from your therapist detailing the requested adaptive/medical equipment (please include the name of the equipment, brand, accessories, and attachments);
2. A detailed quote from your equipment vendor for the adaptive/medical equipment requested (please note that unlocked, Inc. will utilize its own equipment vendors for grant purchases);
3. Letter of denial from your insurance company for the requested adaptive/medical equipment **or** a letter from your insurance company detailing the amount covered for the requested adaptive/medical equipment; and
4. A letter explaining your child's story. Please include as much information as you are willing to share about your child, his/her condition, your family, the reason your child needs the requested equipment and the impact or benefit you hope to achieve from the requested equipment.

Personal Information

Child's Name (First, Middle, Last):	
Address:	
City, State, Zip:	
DOB:	Male/Female:

Parent/Guardian Information

Parent/Guardian Name:	
Address (if different from above):	
City, State, Zip:	
Phone:	Email:
Parent/Guardian Name:	
Address (if different from above):	

City, State, Zip:	
Phone:	Email:

Household Information

Household/Family Size:	Household Annual Income:
Number of Siblings:	Age of Siblings:

Insurance Information

Does Child Have Private Insurance (Y/N)?	
Is Child Eligible for Medicaid (Y/N)?	

Medical History

Child's Diagnosis:	
Age at Diagnosis:	
Areas of Delay:	

Does Your Child:	Yes/No	Is Your Child:	Yes/No
Sit Independently		Vision Impaired	
Crawl		Hearing Impaired	
Walk		Cognitively Impaired	
Speak			
Eat Independently			

Does Your Child Receive:	Yes/No	Frequency

Physical Therapy		
Occupational Therapy		
Speech Therapy		
Feeding Therapy		
Other Therapy		

Equipment Information

Equipment Currently Using:	Yes/No		Yes/No
AFOs/SMOs		Bath Seat	
Gait Trainer		Glasses	
Stander		Arm/Leg Orthotics	
Activity Chair		Wheelchair	
Augmentative & Alternative Communication Device (AAC)		Other Equipment (if yes, include type)	

Equipment Requested

Type:	
Brand:	
Name of Equipment Vendor:	
Name of Therapist Recommending Equipment:	

Misc. Information

Has your child received any other grant(s) (Y/N)?	Which Grant(s)?	Date Received:

How did you hear about unlocked, Inc.?	

If your child receives a grant from unlocked, Inc., would you be willing to share your story with donors (Y/N)?	