REQUEST FOR SPECIAL BEQUEST COMMISSION FUNDING

Date Submitted:	**Date Reviewed:**	
Child's name:		**DOB:**
Recommended by:	**Title/Specialty:**	
Diagnosis:		

Is child seen in SHS Specialty clinic? Yes ☐ No ☐ **If yes, name of clinic(s)** ☐

Has this child been a recipient of Special Bequest funding in the past? Yes ☐ No ☐

If yes, provide summary or attach a funding history: ☐

Item/service requested: ☐

Total cost: ☐ **Amount requested**: ☐

Briefly explain reason for request: ☐

Is item available from Kansas Equipment Exchange (KEE or like program)? Yes ☐ No ☐

Submitted to Medicaid? Yes ☐ No ☐ **Submitted to Insurance?** Yes ☐ No ☐

Does the child receive SSI? Yes ☐ No ☐

List funding resources that have been contacted and response (including family contribution):

☐

Attach a description of health problems, including how the item or service will enhance the child's ability, or reduce the risk of injury to caregivers or child (information should be submitted from a licensed provider, not from a vendor).

Family composition, income and brief social history ☐

Special Health Service contact person: **Office:** SHS, Topeka **Submit Request**

Special Bequest determination:

Approved: ☐ Amount ☐ Denied: ☐ Comments: ☐