Cerebral Palsy Association of Colorado Springs

To request therapy/equipment/service allocation
Please fill out form and return to CPACS
(Allocation Committee meets 2nd Monday of each month)

Name: ____ **Date of Birth:** _________________

Address: ____ **Phone:** _________________

Email: ____ **Today's Date:** _______________

Therapy: OT________ PT_______ Speech_______ Other__________

Specify Other ____

With Whom ___________________How Often _______________Phone _____________

Address ____

Estimated cost of service ____________________Per: Session____ Month ____Wk ___

Is client currently receiving therapy? Yes _______ No _______

Name of therapist ___________________ Location ____________________________

Equipment: Item description and cost (attach picture of item if possible)______________

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Recreation Services:

Therapeutic Riding:

Amount $___________ Where _______________________Sessions ________________

Camperships:

Amount $___________ Where _______________________ Length _________________

Other:

Amount $___________ Where _______________________ Duration ________________

Of this amount how much can you pay? $______________

Total Amount Requested $___________________

Comments ____

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Attach any/all written information to include prescription, justification, etc of need.

Will your insurance pay any portion? Yes __________ No ________

How much will you be able to contribute? ____

Comments: ____