Ariana Rye Foundation

MEDICAL EQUIPMENT APPLICATION

Meet Ariana Rye

Ariana was born prematurely and spent 117 days in Summerlin NICU. She was later diagnosed with spastic quadriplegic cerebral palsy and Auditory Neuropathy Spectrum Disorder. She currently is globally developmentally delayed, non-verbal and non-mobile. As parents of a disabled child, we know the hardships of getting the right care and equipment for your child.

The Ariana Rye Foundation is a 501(c)(3) nonprofit organization dedicated to helping children with disabilities get medical equipment to foster their social, mental and physical development.

Application Requirements:

- Must be located in the United States of America
- Applicants must provide all information listed below including a letter of medical necessity from a licensed pediatrician, physician assistant, nurse practitioner, physical therapist or occupational therapist
- Child must have a qualifying developmental disability with complex needs
- Applicants may apply once per year and may not apply if awarded in the past
- Applicants shall have a $1000 cap per child
- Medical equipment applications will be reviewed and awarded by the board of directors
- Application period will be posted on our website www.arianaryefoundation.com
- Guardian of child agrees to allow Ariana Rye Foundation and its affiliate, Nevada Brew Works, to use child's name, image, likeness, diagnosis, and story. Further, guardian agrees Ariana Rye Foundation, **may or may not,** have a beer labeled in their child's name on tap at Nevada Brew Works
- Applicant must be under the age of 18 years old

Types of equipment considered:

- Feeding chairs, bath chairs, floor sitter chair, car seats, adaptive strollers, mats, wedges, specialty swings, helmets, specialty tables and trays, and sensory equipment

NOTE: The Ariana Rye Foundation provides medical equipment to children in need. The child's legal guardian will be required to submit current pay stubs during the application process.

Please check www.arianaryefoundation.com for application deadlines

Ariana Rye FOUNDATION

Return applications to
lauren@arianaryefoundation.com

APPLICATION

RECIPIENT INFORMATION

Full Name : _____ **Date** : ___/___/___

Primary Diagnosis :

Birthdate : ___/___/___

Address : _____

Phone Number : _____

Gender : ☐ male ☐ female

PARENT OR GUARDIAN INFORMATION :

Full Name : _____

Relationship : _____

Phone : _____

Email : _____

Monthly Income : _____

Does this child live with you? ☐ YES ☐ NO

PEDIATRICIAN INFORMATION

Name(s) : _____ **Phone** : _____

Company : _____

Job Title : ☐ MD ☐ PA-C ☐ NP ☐ DO

Address : _____

THERAPIST

Name(s) : _____ **Phone** : _____

Company : _____

Job Title : ☐ OT ☐ PT ☐ other _____

Address : _____

More Information :
lauren@arianaryefoundation.com
www.arianaryefoundation.com
BE KIND

EQUIPMENT REQUESTED

Cost of Device $ _____ **(must be less than $1000)**

Name of Device : _____

Brand : _____

Website : _____

SKU : _____ **Color** : _____

Please attach website printout of device if necessary

ABOUT THE CHILD

Please describe the applicant's disabilities and developmental delays:

_____

_____

_____

_____

_____

_____

Please describe why the applicant needs requested medical equipment, how it could benefit them, & how often it will be used:

_____

_____

_____

_____

_____

_____

APPLICATION

____ **Complete 5-page application**
____ **Medical information release form**
____ **Letter of medical necessity from healthcare professional**
____ **Equipment request details including type of equipment, size needed, colors, etc.**
____ **Income Verification**

MUST PRINT AND INITIAL

_____ **I hereby declare that the information provided on this application is true and correct. I understand any willful dishonesty may cause denial of application**

_____ **I understand that the Ariana Rye Foundation may contact the applicants' healthcare provider to verify diagnosis and need for equipment**

_____ **I agree to allow the Ariana Rye Foundation and Nevada Brew Works to use my name, pictures/videos, diagnosis and past medical history in social media, website, & other publications**

_____ **I understand if awarded I will be notified via email**

_____ **I understand that the Ariana Rye Foundation may or may not fulfill application request for medical equipment**

_____ **I understand that if the Ariana Rye Foundation approves this application, I will provide pictures of recipient using the equipment to the Ariana Rye Foundation**

_____ **I understand that the Ariana Rye Foundation does not provide any medical advice; always consult a licensed physician**

Parent/ Guardian Print: _____

Parent/ Guardian signature: _____ Date ___ / ___ / ____

Medical Release Form

The parent or guardian of the child listed below has requested consideration for the Ariana Rye Foundation's medical equipment program, which provides medical equipment to disabled children. For more information, please email lauren@arianaryefoundation.com

Instructions

- This medical eligibility form must be completed by an PA-C, DO, MD or NP who has direct knowledge of the patient's medical condition
- Scan this form and email to lauren@arianaryefoundation.com

RECIPIENT INFORMATION

Full Name : _____

Primary Diagnosis :

Birthdate : ____/____/____

Parent/ guardian : _____

PEDIATRICIAN INFORMATION

Company: : _____

Address: : _____

Office phone: : _____

Date: : _____

HEALTHCARE PROVIDER SIGNATURE REQUIRED

We provide medical equipment to families in need with children under 18 years of age diagnosed with a life altering disability.

☐ I confirm diagnosis above and child is eligible to receive medical equipment

☐ Child is not eligible :

Healthcare provider printed name: _____

Healthcare provider signature: _____

Authorization to Release Medical Information

Return form by email to lauren@arianaryefoundation.com

The Ariana Rye Foundation is a 501(c)(3) nonprofit organization dedicated to helping children with disabilities get medical equipment to foster their social, mental and physical development.

I hereby authorize the disclosure of my child's condition and treatment in order to determine qualification for the Ariana Rye Foundation's medical equipment program. For more information, please email lauren@arianaryefoundation.com

Eligibility Determination: We provide medical equipment to families in need with children under 18 years of age diagnosed with a life altering disability.

CHILD INFORMATION

Patient Name : _____ **Birthdate** : ___/___/___

Primary Diagnosis :

Phone Number : _____

Address : _____

Parent/ guardian printed name : _____

_____ **(initials)** I understand that this authorization is voluntary and all records, whether written or in electronic format, are confidential and cannot be disclosed without prior written authorization except provided by law. I understand that a photocopy or fax of this authorization is as valid as the original. This authorization is valid for 12 months from the date of execution.

Parent/Legal Guardian Signature: _____

Date: _____