UHCCF Medical Certification Form

The child listed below is applying for a UHCCF medical grant. All sections are required and must be completed by the child's physician. This form is valid for 6 months following the physician's signature date. The parent/legal guardian must submit the completed form in the online application.

Child's Information

Child's Name: _____ Date of Birth: _____

Primary Diagnosis: _____

Secondary Diagnosis (if applicable): _____

Impact of the child's current or suspected condition: ☐ Medical ☐ Social ☐ Psychological/Behavioral

Goal of recommended services: _____

_____

Recommended Services (Select a maximum of 5 to be considered for grant coverage)

Online application selections must match this form. If "Other" is selected, specify the exact item or service.

Medical Drugs
- ☐ Prescription Drugs

Medical Equipment
- ☐ AAC Device/Speech Generating Device
- ☐ Hearing Aid(s)/FM System
- ☐ Cochlear Implants
- ☐ Orthotics (AFOs, SMOs, Splints)
- ☐ Cranial Orthosis (DOC Band/Helmet)
- ☐ Wheelchair (Power, Sport, Standard)
- ☐ Eyeglasses/Contacts
- ☐ Other Equipment: _____

Medical Therapy
- ☐ ABA Therapy (ages 3-6 only; one grant per child)
- ☐ Therapy (Feeding, Occupational, Physical, Speech)
- ☐ Hippotherapy/Equine Therapy
- ☐ Vision Therapy
- ☐ Mental Health Therapy
- ☐ Other Therapy: _____

Medical Services
- ☐ Ambulance/Medical Transport
- ☐ Inpatient/Outpatient Hospital Stays
- ☐ Diagnostic (Imaging, Labs, Testing)
- ☐ Surgery/Procedures/Treatments
- ☐ Dr/Specialist Visits
- ☐ Tolerance Induction Program (including Dr/Specialist Visits, Labs, Program Fees, Patch Testing, Immunotherapy)
- ☐ Emergency Room/Urgent Care
- ☐ Other Service: _____

Medical Supplies
- ☐ Diabetic Needs (Supplies, Medical Drugs, Equipment)
- ☐ Incontinence Supplies (includes diapers over age 5, catheters, ostomy care)
- ☐ Feeding Supplies
- ☐ Formula/Meal Supplements
- ☐ Other Supplies: _____

Physician Information

SIGNATURE REQUIREMENT: Only MD, DO, and AuD (for hearing-related diagnoses) signatures are accepted. Signatures from NP, PA, APRN, PhD, therapists, or other providers are **not** accepted.

Physician Name: _____ Clinic Name: _____

Credentials: ☐ MD ☐ DO ☐ AuD Address: _____

Provider I.D. #: _____ _____

Phone Number: _____

Physician Signature: _____ Date: _____

Electronic signatures are accepted; typed names are not.