

From which CATS inventory location is this device originating? (Please Circle one)

Roanoke

Richmond

Hampton Roads

DATE _____ This release pertains to equipment donated by Children's Assistive Technology Service (CATS) to the Recipient. The Recipient is PARENT of LEGAL GUARDIAN OF

NAME _____ AGE _____

ADDRESS _____

PHONE _____ EMAIL _____ County _____

Item Inventory Number _____ Description _____

Please read all the conditions below before signing the Equipment Release Form.

- The durable medical equipment I am receiving is a non-prescriptive device and is free of charge.
- CATS does not warrant in any way the condition of the equipment.
- I understand the suitability and the fit of the equipment is to be determined by the user's personal physician, PT, OT, or SLP and CATS does not warrant the equipment is safe or suitable for the child named above.
- I agree to inspect the equipment and understand the equipment may need sanitization and is likely to require adjustment to best suit my child.
- I am responsible for following up on the manufacturer's original warranty, if there is one.
- I am responsible for checking to see if the equipment has been recalled by the FDA by going to the website: <https://www.fda.gov/medical-devices/medical-device-safety/medical-device-recalls>
- I am responsible for any repair or maintenance of the equipment that may be necessary.

I hereby release and hold harmless CATS, its personnel and all persons acting on its behalf from any and all claims by me or my child, or any person(s) acting on my behalf or my child's behalf for any loss, personal injury, liability, expense or damage, including, but not limited to general, specific, incidental, or consequential damages of any kind or nature whatsoever arising from the receipt of this equipment or its use.

Print Name _____

Signature _____

Relationship to Child _____ Date _____

The following is essential information required by CATS funding sources and must be completed. Thank you!

- Is this child currently a client of the Department for Aging and Rehabilitative Services (DARS) VR program?
- Does this child have a traumatic spinal cord injury?
- Does this child have a traumatic brain injury?

The primary purpose for which the child and family needs an AT device or service is related to:

- Education
- Community Living
- Activities of daily living

Why did you choose to obtain an AT device/service from our program?

- I could only afford the AT through this program. I could not afford it through other programs.
- The AT was only available to me through this program. I am not eligible or don't qualify for other programs, the AT is not covered by other funding sources or the specific device I needed is not provided by other programs.
- The AT was available to me through other programs, but the system was too complex, or the wait time was too long

Which of the following best reflects your level of satisfaction with this means of obtaining needed equipment?

- Highly satisfied
- Satisfied
- Satisfied somewhat
- Not at all satisfied

Completed by _____ Date: _____

Parents/ Caregivers should expect to receive a follow up survey 3 to 4 months after receiving equipment.

Responses to the survey are greatly appreciated.