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| *North Carolina Infant-Toddler Program* |  |

*Assistive Technology Loan Agreement*

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| **Child’s Name:** | |  | | | | **Child’s Date of Birth:** |  | | | |  | | | |
| **Date Equipment Received by CDSA:** | | | | |  | **Date Delivered to Family/Provider:** | |  | | | | |  | |
|  | | | | |  |  | | | |  | | |  | |
| **Inv.#:** |  | | **Item:** |  | | | | | **Value:** | | | $ | |
| **Inv.#:** |  | | **Item:** |  | | | | | **Value:** | | | $ | |
| **Inv.#:** |  | | **Item:** |  | | | | | **Value:** | | | $ | |
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| I am the responsible person for this loan, and I agree to the following as indicated by my initials (& signature below): | | | | | | | | | | | | | | | | | | |
| **Service Provider:** | | | | | | | | | | | | | | | | | | |
|  | 1. The device received is clean and in working condition. Batteries were supplied if appropriate. (Batteries will only be provided at initial time of loan.) | | | | | | | | | | | | | | | | | |
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|  | 2. The device will only be used with the designated child (the device is not transferable). | | | | | | | | | | | | | | | | | |
|  | 3. **I understand that the use of this assistive technology (AT) is by LOAN. I agree to return the AT when no longer needed** for assessment and equipment trial or to transfer the loan to the designated family as determined by the IFSP team and facilitated by the EISC. | | | | | | | | | | | | | | | | | |
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| **Family:** | | | | | | | | | | | | | | | | | | |
|  | 1. The device received is clean and in working condition. Batteries were supplied if appropriate. (Batteries will only be provided at initial time of loan.) | | | | | | | | | | | | | | | | | |
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|  | 2. I was instructed in the proper use and care of the device and how the device will assist in addressing the IFSP outcome. I agree to be responsible for the proper use, care, cleaning, and maintenance of the device. | | | | | | | | | | | | | | | | | |
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|  | 3. I agree to notify the EISC if the device is not working properly. The item will not be adapted or altered in any permanent way. | | | | | | | | | | | | | | | | | |
|  | 4. The device will only be used with the designated child. | | | | | | | | | | | | | | | | | |
|  | 5. I agree to routinely communicate with my child’s EISC and IFSP team regarding the continued need and use of the device in relation to achieving the IFSP outcome(s). | | | | | | | | | | | | | | | | | |
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|  | 6. I understand that I can request on-going assistance and training from the EISC related to use of the device to meet the IFSP outcome. The EISC will coordinate appropriate personnel to provide assistance | | | | | | | | | | | | | | | | | |
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|  | 7. **I understand that the use of this assistive technology (AT) is by LOAN. I agree to return the AT when no longer needed** to achieve an IFSP outcome, when my child is no longer enrolled, or when my child exits the Infant-Toddler Program. | | | | | | | | | | | | | | | | | |
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|  | 8. **I understand that I may be responsible for a lost, damaged, or unreturned device on loan to my child.** | | | | | | | | | | | | | | | | | |
| **Signature:** | | |  | | | | | | **Date Received:** | |  | | | | | |  | |
| **Print Name:** | | | |  | | | | | **Relationship to Child:** | | | |  | | | |  | |
| **Service Provider’s Name:** | | | | |  | | **Service Provider’s Signature:** | | | | | |  | | | | |  |
| Name of Service Provider’s Agency: | | | | | |  | | | | | | | | | | | |  |
| Address: | |  | | | | | | City: | |  | | State: | |  | Zip Code: |  | |  |
|  | | | | | | | | | | | | | | | | | | |