Equipment/Supplies Application Form

Client Name _____ **Phone ( )** _____

Address _____ **Client Date of Birth** _____/_____/_____

City _____ **State**_____ **Zip**_____ **Email Address**_____

Primary Language Spoken:_____

Who referred you to Clinics Can Help? _____

Person (if other than client) Picking Up Equipment/Supplies **Phone ( )**_____

_____

Relationship to Client _____ **Email Address**_____

Address _____

City _____ **State** ____ **Zip** _____

To provide our funders with the most accurate information about the people we serve please complete the following questions.

Does the client have medical insurance? (please circle): No Yes
If so, what kind? (please circle): Medicare Medicaid Health Care District PBC Other:_____

If the client has medical insurance have they applied for purchase of or payment of the equipment being requested? (please circle): No Yes If no, why not? _____

Was it denied? (please circle): No Yes If yes, why was equipment denied?

_____

_____

Diagnosis (please circle): Cardiac Respiratory Trauma Neurological Cancer Congenital Disorder Diabetes Dementia Gastro-Intestinal Infection Orthopedic

Client's Gender (please check): __ Male __ Female Is the client a Veteran? (please circle): Yes No

Client's Ethnicity (please check): ____White/ Non Hispanic ___African American ___Asian American ___Caribbean Islander ___Latin American ___American Indian ____Pacific Islander

Client's Education (please check): ___ Elementary ___ High School/GED ___ College ___ Master's Degree

Client's Annual Income Level (please check):
___under $25,000 ___$26 to $50,000 ___$51 to $75,000 ___$76 to $100,000 ____>$100,000

Equipment applying for: _____

_____

I agree that I will return the equipment in the same condition when my (or my child's or the person whom I care for's) present physical need no longer exists. The equipment/device was inspected and found to be assembled, clean and functional at the time of pick up. Safety checks were performed along with return demonstration from the person(s) picking up equipment/device. I understand the instructions provided including safety check and proper use. I hereby release and hold harmless Clinics Can Help, its members, agents, or employees from any claim by me, or any person acting for me or on my behalf for any injury, loss, expense, or damage, including but not limited to general, specific, incidental, or consequential damages, of any kind or nature whatsoever arising from this equipment or its use. I also give Clinics Can Help permission to take my photo and to use it in any and all promotional venues as related to Clinics Can Help.

CPAP/NEBULIZER/Oxygen Concentrator: I acknowledge that I am under the care of a physician and will not use this equipment without receipt of instructions on its use and care from my heath care provider. _____ **(Initials)**

Signature of Client/Legal Guardian/Advocate/Caregiver: _____ **Date:** _____

Clinics Can Help
2560 Westgate Avenue WPB, FL 33409
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www.ClinicsCanHelp.org

Date entered into database_____ **Donation Made:** _____

Member of Vulnerable Population: Yes or No. If Yes, why? _____