



# 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  Multi Ethnic

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. All returned equipment is subject to a 20% restocking fee with 14 days' notice from date of acceptance of equipment. 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 health care provider. \_\_\_\_\_ (Initials)

Signature of Client/Legal Guardian/Advocate/Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_

Clinics Can Help  
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[www.ClinicsCanHelp.org](http://www.ClinicsCanHelp.org)

|                                  |                      |
|----------------------------------|----------------------|
| Date entered into database _____ | Donation Made: _____ |
|                                  | Initials: _____      |