Clinics Can Help Application Form

Client Name _____ **Phone ( )** _____

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

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

Who referred you to Clinics Can Help? _____

Name of Person Picking Up Equipment **Phone ( )**_____

_____

Relationship to Client _____ **Email Address:**

Address _____ _____

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

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

Do you have medical insurance? (please circle): Yes No. If so, what kind? (please circle): Medicare Medicaid

Healthcare District Other:_____.

Have you applied to your insurance for this medical equipment? (please circle) Yes No.

Was it denied? Yes No. If so, why?:_____.

Diagnosis: Cardiac Respiratory Trauma Neurological Cancer Congenital Disorder Diabetes Dementia

Gastro-Intestinal Infection Orthopedic

Client Gender: __ Male __ Female Are you Veteran? Yes or No

Ethnicity: African American Asian American Caucasian Caribbean Islander Latin American American Indian

Client Education: ___ Elementary ___ High School/GED ___ College ___ Master's Degree

Client Income Level: ___under $25,000 ____$26 to $50,000___$51 to $75,000 ___$76 to $100,000 ____>$100,000

Equipment Applying For:

_____

_____

I acknowledge that the above-identified equipment was inspected by me, or the person responsible noted above and at the time I received the equipment it was clean and in good condition. I agree that I will return the equipment in the same condition when my (or my child's) present physical need no longer exists. I will not permit this equipment to be transferred to another person under any circumstances, and while this equipment is in my possession, I will notify you of any change of address for me. I will not take this equipment out of the area served by Clinics Can Help. 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 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 agree that Clinics Can Help, its members, agents, volunteers or employees have made no representation of any kind whatsoever expressed or implied, to me with regard to the condition of the equipment provided or as to the use to which the equipment is to be put. I also give Clinics Can Help permission to take my photo and to use it in any and all promotional venues.

CPAP/NEBULIZER RIDER: 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 _____ **Date**_____

2560 Westgate Ave WPB, Fl. 33409
Phone: (561) 640-2995 Fax: (561) 640-1881

FOR OFFICE USE ONLY
Date entered into database_____

Donation made _____

Initials