Equipment Services Application

Applicant's Name:

_____

Address: _____County: _____ Telephone: _____

City: _____State: _____ Zip Code:_____

Birthdate:_____ Sex: ____ Height: _____ Weight: _____ Disability_____

Name of parent/guardian, spouse, or next of kin: _____

Equipment Requested:_____

_____

Do you use any other Easterseals Iowa program(s)? ☐ Yes ☐ No

If yes, which program(s)?

_____

Are you employed in the community? ☐ Yes ☐ No

Military Status: ☐ Active Duty ☐ National Guard/Reserve ☐ Veteran

☐ Member Military/Veteran Family (child, spouse, or parent) ☐ N/A

I plan to use this equipment for: (check ALL that apply)

☐ My job ☐ In my home/community ☐ In an educational setting

Check ONE that applies:

☐ Without Easterseals Iowa I could **not** afford this equipment.

☐ The equipment was only available through Easterseals Iowa.

☐ The equipment was available through other programs, but the system was too complex or too long.

Limited scholarships are available upon request.

OPTIONAL – (Information is used for tracking purposes only. Information is kept confidential.)
Please indicate which ethnic group you identify yourself with:

☐ African American ☐ Asian American ☐ Caucasian ☐ Hispanic ☐ Native American

☐ Multiple Ethnicities ☐ Other

Waiver of Liability:

The undersigned, individually or as a parent or guardian, in partial recognition of services rendered and benefits conferred by Easterseals Iowa, hereby releases and forever discharges Easterseals Iowa, its agents and assigns, from any and all claims, demands or actions, causes of actions, or suits of whatsoever kind or nature of damages sustained by the above named client or accruing to the undersigned in consequence of any accident or occurrence resulting from use of durable medical equipment and/or participation in any program of Easterseals Iowa, and when the above named client is not on the premises of said Easterseals Iowa, and is engaged in any venture or activity solely on his or her own behalf.

Signature: _____ Date: _____

Witness: _____ Date: _____

Assessment Form:
To be completed by a physician, physical therapist, or other medical professional.

Patient's Name: _____

Name and address of physician, physical therapist or medical professional:

_____

_____

Diagnosis (list all disabling conditions):

_____

_____

Functional Limitations (relative to the patients' need for equipment or services):

_____

_____

Equipment Requested: _____

The physician, physical therapist, or medical professional's signature on this form will indicate that the equipment or service is medically necessary and prescribed to them.

Signature: _____ Date: _____

Printed Signature: _____ Date: _____

It is Easterseals Iowa's intent to make available equipment that is in proper working order. If within 14 days of receiving equipment, the consumer or caretaker determines it is not in proper working order, Easterseals Iowa must be notified immediately. At that time, Easterseals Iowa will make every effort to fix the equipment, determine if an exchange can be made, or refund the equipment fee. Delivery fees are not refundable. After 14 days from the original loan date, it is the consumer's responsibility to repair or maintain the equipment or dispose of it properly.

For Office Use Only:
Equipment borrowed: _____

Identification number (s): _____

Check-Out Date: _____

Fee Paid: _____

Return Date: _____