Equipment Services Application

In partnership with Easterseals Iowa, ARK serves Dubuque and the surrounding area.

Applicant’s Name: Address: County: Telephone:

City: State: Zip Code:

Birthdate: Sex: Height: Weight: Disability

Name of spouse or next of kin:

Equipment Requested:

Do you receive Medicaid?

Yes

No

Unsure

Are you employed in the community? Yes No

Military Status:

Active Duty

National Guard/Reserve

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

Veteran

N/A

**I plan to use this equipment for: (check ONE that applies)**

My job In my home/community In an educational setting

**Check ONE that applies:**

Without Easterseals I could **not** afford this

The equipment was only available through Easterseals Iowa

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

**OPTIONAL – (Information is used for tracking purposes only. Information is kept confidential.)**

**Please indicate which ethnic group you identify yourself with:**

African American

Native American

Asian American Caucasian

Hispanic

Multiple Ethnicities

Other

**What is the purpose of this loan?**

Assist in decision making

Serve as a loaner during device repair or while waiting on funding

Provide an accommodation on a short-term basis

# 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:

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 that 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.

**For Office Use Only:**

Equipment borrowed: Identification number(s): Check-Out Date: Fee Paid: Return Date:

# To be completed by a licensed educator or medical professional familiar with applicant.

Applicant’s name: Name and address of licensed educator or medical professional:

Diagnosis (list all disabling conditions):

ICD 10 code(s) for diagnosis:

Equipment requested:

**The educational / medical professional's signature below indicates that the equipment or service will** **enhance the applicant’s health / wellbeing by assisting in their ability to complete ADL's, access recreational opportunities, and/or promote inclusion within their home/community.**

Signature: Date:

Printed Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_