



# 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 ONE that applies)**

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.

**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

**OPTIONAL - Have you received the COVID-19 Vaccine?**

- Yes- I have received one dose  Yes- I have received both doses
- No – will be declining

If yes, please list the type of vaccine received (Moderna, Pfizer, Johnson & Johnson): \_\_\_\_\_

**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):

\_\_\_\_\_

ICD 10 code(s) for diagnosis:

\_\_\_\_\_

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: \_\_\_\_\_