Application date: _____/_____/____ *Staff Initials:*_____

Full Circle DME
Donation Request Form

Client information:

First name Last name:_____

Telephone: ( ) _____--_____ Cell: ( ) _____--_____

Date of birth: ____/____/_____ SSN (last 4 digits): _____

E-mail:_____

Height: _____ Weight: _____ Age:_____ Med. Diagnosis:_____

Address:_____City:_____

State:_____ County:_____ Zip:_____ Sex:_____ Race:_____

Do you have: Medicaid? ☐yes ☐no Medicare? ☐yes ☐no

Veteran? ☐yes ☐no VR Client? ☐yes ☐no Paid Income Taxes Last Year? ☐yes ☐no

1st time Client? ☐yes ☐no Church you attend (optional):_____

Living arrangements: ☐Nursing home? ☐Asst living? ☐Family/friends? ☐Independent? _____

Client Representative:_____ _____ ***Relationship***:_____

Organization: _____Telephone: ( ) _____--_____

REQUESTED ITEMS

_____
_____
_____
_____
_____
_____
_____
_____

"I have been shown how to safely use the equipment I am receiving from Full Circle DME Donation Program."

Name:_____ Signature:_____

*If not the direct user: "I have been shown how to safely use the equipment I am picking up or I will explain these methods to the direct user or caregiver who will use it."

Name:_____ Signature:_____

Name of direct user of equipment: _____

Satisfaction Survey

If you would like to tell us how an item you are getting will affect your life, we would like to hear about it. By telling us your story, you are giving us permission to use your story on the web, in our newsletters, and in grant requests to potential donors.

_____
_____
_____
_____
_____
_____
_____

How satisfied are you with the equipment you received?
☐ Very Satisfied ☐ Somewhat Dissatisfied
☐ Somewhat Satisfied ☐ Very Dissatisfied

My disability is (check one):
☐ Temporary ☐ Permanent

This item(s) will help me in which of the following areas (check all that apply):
☐ Increased Mobility ☐ Increased Independence
☐ Physical Development ☐ Attend School
☐ Go to Work ☐ Able to go to doctor's appointments

Which of the following has been the biggest barrier that has prevented you from getting the equipment you need?
☐ Lack of Funds ☐ Medicaid/Medicare Delay
☐ Medicare/Medicaid Denial

Have you exhausted all other resources to get this equipment?
☐ Yes ☐ No

Will this equipment help reduce falls? ☐ Yes ☐ No

Will this equipment provide assistance to caregivers? ☐ Yes ☐ No