DATE____________________ITEM REQUESTED ____

Medical Equipment /Computer Loan Program Intake

Ramps, mini ramp and grab bars only

1. Dr.'s script must include the diagnoses medically necessary 2. H. M. A. (only if they rent) __OWN

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1. Name____ DOB ___________________Gender M F

2. Address ___________________________________City _______________Zip Code _____ (Last 4) SS#______

3. Home #_____________________Height _____ **Weight_____ Disability_______________________________**

4. Power Of Attorney Y N If yes who _________________________ Phone # __________________________

5. Caucasian African American Hispanic Veteran Y/N Retired, Unemployed or Employed___________________

6. Independent, Family & Friends Assistant Living or Homeless

7. How many children under 17 live in the home? _____ How many adults? _____ (Household Income)________

8. Your MONTHLY income _____________including child support SSI, SSDI, AFDC or Family Support

Adult #1________ Adult #2 __________Adult #3 _______Do you receive FOOD STAMPS (Y/N)__________

9. Emer. Contact Name ________________________Phone # ___________________ Email ___________________

STAFF ONLY

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Date Documentation letter received__________________

Dr.'s scrip; for grab bars & ramps.

H. M. A.; for ramps & grab bars

Income verification: Awards letter or back statement.

Proof of residency; utility bill, phone bill…..

Mail to: Suncoast Center for Independent Living Attn: Mobility Coordinator 3281 17th Street Sarasota, FL 34235

Fax: 941-316-9320

Email: Mobilitycoordinator@scil4u.org