Assist M.E. (Medical Equipment) Charlotte, N.C. Assist M.E. Giving The Gift Of Mobility	AssistMENC@gmail.com 704 659 1123

Application Cover Sheet

Dear Applicant,

Thank you for your interest in the Charlotte Mobility Assistance Program. We hope to help you in your time of need. Please fill out all information on the attached form. **We may call you if you have not filled out all parts of the form or if we need to know more information about your needs.**

We hope to be able to help you. We recycle gently used equipment donated by people in the community. If we do not have the equipment you need, we may not be able to help, but we will do our best to meet your need. Our goal is to help people who do not have medical insurance or the money to pay for the equipment they need. Please check with your church, family, and friends before you accept any equipment from Assist M.E.

Please note that you need to have your doctor write a prescription for your equipment. Attach the prescription to your completed application. **Assist M.E does not gift respiratory equipment such as nebulizers or CPAP machines.**
** **If we are able to meet your need, please know that the equipment you receive is a gift and is your responsibility to maintain. Assist M.E is not responsible for any repairs or injuries caused by using the equipment.**

Sincerely,

Jack Sheehan,
President
AssistMENC@gmail.com

Remember to:

☐ **Complete all parts** of this application. It is okay for someone to help you fill it out.

☐ **Sign & date the application** (page 2)

☐ **Attach** the prescription from your doctor (Required for **ALL** equipment)

☐ **Sign Release of Medical Information/Waiver Form (page 3)**

Application

Applicant's name _____ DOB _____

Telephone ( ) _____ Room # (if in Hospital or nursing home) _____

Address _____City of_____ Expected Discharge _____

E-mail Address of Patient _____

Person helping with application: _____ Phone ( ) _____

E-mail address of person helping _____

Demographics (For reporting only. This information does not affect whether you receive equipment.)

Age: _____ **Gender:** ☐ **M** ☐ **F** **Height:** _____ **Weight:** _____

Employment status: ☐ Retired ☐ Employed ☐ Unemployed **US Military Veteran:** ☐ **Y** ☐ **N**

Race: ☐ African-Amer ☐ Asian-Amer ☐ Hispanic-Amer ☐ Caucasian ☐ Other_____

Will the equipment help with any of the following? (Check all the apply)

☐ Home ☐ School ☐ Work ☐ Community activities

1. What medical problems do you have and when did they start? _____

_____

2. Your Doctor's name: _____ Doctor's Phone # _____

3. What equipment is needed? _____
(Attach an order from your doctor.)

4. What equipment do you use now? _____

5. Is anyone able to help you pay for your equipment? ☐ Family ☐ Church ☐ Other

6. What are your Monthly Medical expenses that are not covered by your insurance? $ _____

7. Current financial status:

HOUSEHOLD MONTHLY income (taxable & non-taxable) $ _____

Total value of Assets (real estate and property values) $ _____

Number of Dependents living in your house (including yourself) _____

8. Please check if you have:

☐ Health Insurance ☐ Medicare ☐ Medicaid ☐ **I DO NOT have any insurance**

Please provide: Policy name _____

The undersigned certifies that all information provided within this application is accurate to the best of your knowledge and is subject to verification.

Signature: X **Date:**

Authorization to Release Medical and Financial Information/Waiver Agreement

Name _____
(Please print)

Telephone _____

Equipment needed: _____.

I, _____ , the applicant, understand that filling out this form does not mean I will receive any equipment. I understand that if I do receive any equipment, it is a gift to me from Jack Sheehan and the Assist M.E. organization and that this gift may be a recycled item. If I receive any equipment, I accept all responsibilities for the equipment and give up any right to sue or hold Jack Sheehan or the Assist M.E. organization, their members, officers, directors and any of their representatives responsible for any injury that could result from using the equipment. I also understand that I am responsible for any repairs the equipment may need. I understand that in return for getting this equipment for free, I give up any claim I may have against the above listed individuals and organization.

I, the undersigned, give the Assist M.E organization permission to review my medical records and get any information they need from my doctor to justify the need for my equipment.

X_____ _____

Signature of Applicant or Caregiver **Date**

Please keep your equipment as long as you need it. When your injuries are healed and you don't need your equipment anymore, you can donate it back to us so we can use it for someone else in need.

Call 704-659-1123 and we can arrange drop off or pick up.