

FINANCIAL ASSISTANCE APPLICATION

Patient's Name: _____

Parent or Guardian: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Patient's Date of Birth: _____

Diagnosis: _____

EQUIPMENT (include prescription(s)):

Item(s) Prescribed: _____ Wheelchair _____ Braces _____ Crutches
_____ Other: _____

EQUIPMENT COST (approximate):

\$ _____ Wheelchair

\$ _____ Braces

\$ _____ Crutches

\$ _____ Other

EQUIPMENT PROVIDER:

Name: _____

Address: _____

Phone: _____

PRESCRIBING AUTHORITY:

Doctor: _____

Facility: _____

Address: _____

Phone: _____

Other Relevant Information: _____

INSURANCE:

Insurance Coverage? _____ Y _____ N

Covered Amount: _____

I, _____, give permission to the SBAKC to contact the prescribing authority and equipment provider above for specific information on the patient's case and necessary equipment.

Signature: _____

Relationship to Patient: _____

Date: _____

SBAKC USE ONLY

Date Approved: _____

Amount: _____

Chk #: _____

SBAKC Representative