community league
NURTURING ST. MARY MEDICAL CENTER FOR A HEALTHIER TOMORROW

CARES Application

OFFICE USE ONLY

DATE APPLICATION RECEIVED_____ ALL INFORMATION RECEIVED_____

☐ APPROVED

☐ DENIED DUE TO_____ DELIVERY DATE_____

Applicant's name_____ Date of birth_____

Telephone (_____)_____ Email _____

Address_____ City_____ Zip_____

Is someone helping you complete this application? _____Yes _____No

If yes, please complete this section : Advocate helping with ☐ application_____

Phone (_____)_____ Email_____

Demographics (For reporting use only. This information does not affect the outcome of your request.)

Age_____ **Gender** (please circle one): **M** **F** **Height:**_____ **Weight:**_____

Employment status: ☐ Retired ☐ Employed ☐ Unemployed

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

Will the requested device help with any of the following? (Check all that apply)

☐ Home ☐ School ☐ Work ☐ Community activities

1.) What type of equipment is being requested?_____

Are there any special accommodations required? _____

(Please note: Some equipment may require a physician prescription)

2.) Do you currently use an assistive device? ____Yes _____No If yes, what is the assistive device?_____

3.) Can another source help you with the purchase of the requested item? ☐ Family ☐ Church ☐ Other_____

4.) Current financial status: Applicant's MONTHLY HOUSEHOLD income $_____

5.) Number of dependents living in household (including applicant) _____

6.) Please check if you currently have: ☐ Health Insurance ☐ Medicare ☐ Medicaid

☐ **I DO NOT have any insurance** ☐ Other_____

7) Have you attempted to obtain this equipment through your insurance carrier? _____

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

Signature **Date:**