REQUIRED DOCUMENTS:

➢ Nevada Photo ID and Proof of Nevada Address

➢ Application

➢ Proof of Income

➢ Release form - Must be signed by applicant

   (Exceptions may be made for pick-ups after form is signed or with Power of Attorney documentation)

➢ Prescriptions Required

   Nebulizer / Walker with Seat / Liquid Nutritional Supplements / Diabetic Test Strips / Power Operated Vehicles (Scooters) / Blood Pressure Monitors / Catheters Incontinence supplies / Pulse oximeter

Other: __________________________________________________

________________________________________________

Thank you,
CARE Chest

Revised 11/18/19
First Name: ___________________________ Last Name: ___________________________

Social Security #:_______-____-_______ Date of Birth: _______/_____/_______

Gender: M/F Time lived in NV: ________

Race (Circle One): Asian/Black/Caucasian/Hispanic/Native American/Other

Insurance (Circle all that apply): None/Medicare/ Medicaid/Private /Other: ______________________________

Medical Condition(s): ______________________________

Physician/Healthcare Provider: _________________ Are you a veteran? Y/N

Client Address: _________________________________ City: ______________________

State: ___ Zip: ________ Phone: ______________________ Email: ______________________

# in Household: ______ # Adults: _____ Are you the head of household? Y/N

Contact Person: _________________________________

Contact Person’s Phone: __________________________ Relationship to you? ______________

How were you referred to CARE Chest? __________________________________________

Employment: Y/N Employer: ______________________________________________________

If not, are you (circle one) retired/disabled?

Monthly Household Income (including Social Security benefits, pensions, etc.) ____________

Services Requested from CARE Chest: ______________________________________________

__________________________________________________________________________________

Please refer to the Required Documents page to complete the application process.

Expenses (For Internal Use Only)

Rent/Mtg _______ Utilities _______ Transportation _______ Medical Expenses _______

Child Care _______ Food & Clothing _______ Credit Payments _______ Other _______

Total Expenses $__________ Amount Left $__________

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Verification of Income Statement

This is to certify that my/our total income is $________________, which includes any benefits or assistance and provides for my family of _______________.

The above statements are true and correct.

Signature: __________________________

Print: ____________________________

Date: ____________________________
RELEASE AGREEMENT

It is understood that the equipment received is the property of CARE Chest of Sierra Nevada and is loaned at no cost to the patient for his/her comfort and use; this loan is subject to the following conditions:

1) The undersigned acknowledges that the information on this form is true and correct to the best of his/her knowledge and that all guidelines for CARE Chest’s program qualifications have been met. The undersigned agrees to notify CARE Chest of Sierra Nevada of any change in status from that indicated on this form.

2) The undersigned acknowledges that the equipment, supplies and services received have been used/may have been altered and hereby acknowledges receipt of same.

3) In consideration for the use of the equipment received, the undersigned on behalf of himself, his spouse, legal representatives, heirs and assigns, hereby releases, waives and discharges CARE Chest of Sierra Nevada, its members, directors, officers and employees (hereinafter referred to as “Releasees”) from all liability to the undersigned, undersigned’s spouse, legal representatives, heirs and assigns for any and all loss or damage, and any claim or damages resulting there from, on account of injury to the undersigned or the undersigned’s property, including but not limited to, injury resulting in death of the undersigned, whether caused by the negligence of Releasees or otherwise, resulting from the use of the equipment received. The undersigned agrees to indemnify the Releasees and each of them from any loss, liability, damage or costs (including attorneys’ fees) that they may incur due to the loaning of the equipment received. The undersigned assumes full responsibility for the risk of bodily injury, death or property damage from the use of the equipment received. The undersigned agrees that this release is intended to be as broad and inclusive as permitted by the laws of the State of Nevada, and that if any portion thereof is held invalid, it is agreed that the balance shall; notwithstanding, continue in full legal force and effect.

4) The undersigned hereby agrees to be responsible for the equipment received; if said equipment is misused, damaged or destroyed while in the patient’s possession, the undersigned will take full responsibility for the reasonable cost of repairs or replacement.

5) **Initials Required** The undersigned may borrow the equipment for: ____ short term waived or ____ long term and agrees to return equipment promptly, in the same condition as received (except for normal and reasonable wear), as soon as the need no longer exists. The undersigned further agrees to return the equipment in clean condition.

6) Yes _____ No_____ The undersigned hereby grants permission to CARE Chest of Sierra Nevada to release the patient’s name and/or any relevant case information (which may include writings, photos, and/or biographical data) for the purpose of public education and awareness, promotion of services, solicitation of contributions, and/or any other constructive purpose in the furtherance of the objectives and purpose of CARE Chest of Sierra Nevada.

INDEPENDENT LIVING PROGRAM:

7) Yes _____ No_____ N/A _______ I understand that by signing this authorization I give CARE Chest of Sierra Nevada permission to share my personal information and transfer information electronically, via fax or email; with any and all contractors, vendors and companies involved with providing services associated with my Independent Living application and plan of service.

_________________________________________________________ / ______________________________________
**CLIENT SIGNATURE** Date

**Or designated responsible party, such as Power of Attorney or Legal Guardian (must provide documentation if client is over 18 years of age)**

Print Name: ___________________________________________
Phone: _______________________________________________
DOB: _________________________________________________
SSN: _________________________________________________