

Special Needs Kids, Inc.

An Adaptive Equipment Lending Library

Durable Medical Equipment Request Form

Client Information

First Name _____ Last Name _____

Date of Birth ____/____/____ Medicaid Recipient Yes No

Diagnoses _____

Street Address _____

City _____ State _____ Zip _____

Parent/Guardian Information

First Name _____ Last Name _____

Relationship to Client _____ Resides with Client Yes No

Address (if different from client) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Loaned Equipment Information (for office only)

Description of Item _____

Inventory Control # _____ Liability Waiver Received Yes No

Anticipated Length of Loan 3 months 6 months 9 months 12 months

Issue Date ____/____/____ Return Date ____/____/____ Issuer Initials _____

Signature of Parent/Guardian _____ Date ____/____/____

By signing this form, the above named parent/guardian hereby acknowledges receipt of the specified equipment in good condition and working order on the date indicated.