Dear New Patient,

Welcome and thank you for choosing Skilled Mobility for your home healthcare needs! Enclosed is a letter with the form for the resident's wheelchair we discussed. For us to move forward with ordering the wheelchair we must obtain this signed document back first. Below is an explanation of the form. Please call me or email me if you have any questions.

• IME agreement – just confirming that you understand if there is a change in status (I.E. death, hospice or change of facility) during the duration of the chair being paid, please notify us so that we can pick up the wheelchair if needed. Once the chair is paid off it belongs to the resident or their legal authorized representative.

Please complete and sign the "Incurred Medical Expense Agreement" at your earliest convenience and return them to us in the enclosed self-addressed, stamped envelope. ***Please note that these forms need to be on file with our office before we can deliver your equipment .*** Once your equipment is delivered please sign the "Delivery Receipt".

We pride ourselves on our outstanding customer service, products and deliveries. Please contact us with any questions or comments.

Thank you for choosing Skilled Mobility. We look forward to working with you!

Sincerely

Skilled Mobility

Phone: 512-846-3155 Fax: 832-218-0333

Incurred
Medical Expense Agreement

1. I understand that according to the Texas Health and Human Services Commission, Medicaid for the Elderly and People with Disabilities Handbook Chapter H Section 2000, an allowable deduction includes customized manual wheelchairs. _____ (INITIALS)

2. I understand that ownership of the equipment is not fully executed until the purchase price has been met and paid in full to Skilled Mobility. _____
(INITIALS)

3. I understand that as my family member's legal authorized representative I am required to notify Skilled Mobility within 72 hours of a change of status that might occur during the pay off period of the equipment. This includes status change to hospice, discharging the facility, and the passing of the resident for whom the equipment is intended.
_____ (INITIALS)

4. I understand that in order for Skilled Mobility to order the medically necessary equipment for my family member I must return this form signed and dated. _____
(INITIALS)

5. I acknowledge that I have received a patient packet. _____ (INITIALS)

Patient: _____

Print Name of Legal Authorized Representative_____

Signature of Legal Authorized Representative _____ Date_____

Print Name of Resident _____