



# EQUIPMENT FORM

## PERSONAL INFORMATION

Full Name :

(PLEASE USE CAPITAL)

Child's Full Name :

Birthdate : \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender :  Male  Female

Address :

Phone Number :  Email :

Insurance :  Insurance ID :

Equipment Status :  Accepted  Denied  Not Applied  Other T-shirt Size :

Diagnosis :  Can We Share Your Story w/ photo/video :  Yes  No

rights if applicable

Equipment Applying For : Attach Separate Page for Measurements/Details

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## MEDICAL CONTACTS: PCP -OR- SPECIALIST

Contact Name :  Contact Name :

Phone # :  Phone # :

## OFFICE USE ONLY

Date Recieved :  Amount :

Date Review :  Date Ordered :

Decision :  Date Received :

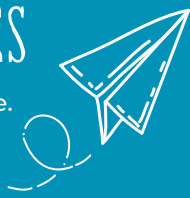
### More Information :

PO BOX #463 Grants Pass, OR 97528

(877) 354-7365

[www.mecdisabilities.org](http://www.mecdisabilities.org)

**THANK YOU**



# EQUIPMENT FORM

## EQUIPMENT INFORMATION

Equipment Needed  
*(PLEASE USE CAPITAL)*

:

Who Recommended

:

Please attach letter of medical necessity or recommendation. Along with prescription and insurance denial if applicable. You will hear a decision within 120 days of MEC Disabilities receiving the completed application.

If we need any other information or documentation to get the equipment we will contact you at your preferred method of contact. After 3 tries and fails of contact your application will be filed and on hand for 1 year. Please contact us if anything changes such as measurements etc.

### Measurements/Details

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## DELIVERY IF ACCEPTED

Please select below your preferred method of contact and if personal delivery is ok. In most cases the equipment will be delivered by the company we order from but it can potentially be delivered by a board member of MEC Disabilities if ok.

Phone  Email

In Person Delivery OK  In Person Delivery **Not** OK

## OFFICE USE ONLY

Equipment Information : \_\_\_\_\_

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**THANK YOU**

