

**SOUTHWEST MICHIGAN REHAB FOUNDATION**  
**APPLICATION FOR FINANCIAL ASSISTANCE**

**IMPORTANT! FOR THIS APPLICATION TO BE PROCESSED, YOU MUST INCLUDE THE FOLLOWING:**

1. THIS APPLICATION, COMPLETED AND **SIGNED BY APPLICANT**. PLEASE PRINT CLEARLY!
2. A DOCTOR'S PRESCRIPTION FOR THE EQUIPMENT OR SUPPLIES YOU ARE REQUESTING.
3. IF YOUR TOTAL REQUEST IS **OVER \$200**, TWO (2) BIDS FROM DIFFERENT SUPPLIERS, ON THEIR LETTERHEAD. IF YOUR TOTAL REQUEST IS **UNDER \$200**, ONLY ONE (1) BID IS REQUIRED.

NAME OF APPLICANT: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ SEX (Circle One): Male Female

If it applies, name, phone number, and relationship of legal representative: \_\_\_\_\_

Occupation and name of employer: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_

Other agencies applied to for assistance: \_\_\_\_\_

Medical diagnosis: \_\_\_\_\_

Equipment requested: \_\_\_\_\_

Do you own your own home? Yes \_\_\_\_\_ No \_\_\_\_\_ Number of persons (including applicant) in household: \_\_\_\_\_

**MONTHLY HOUSEHOLD INCOME - Include name and income of everyone in the residence.**

|                     | Applicant       | Person #2       | Person #3       | Person #4       |
|---------------------|-----------------|-----------------|-----------------|-----------------|
| Name:               | _____           | _____           | _____           | _____           |
| Age:                | _____           | _____           | _____           | _____           |
| Take home wages     | \$ _____        | \$ _____        | \$ _____        | \$ _____        |
| Social Security     | \$ _____        | \$ _____        | \$ _____        | \$ _____        |
| Pension             | \$ _____        | \$ _____        | \$ _____        | \$ _____        |
| Child Support       | \$ _____        | \$ _____        | \$ _____        | \$ _____        |
| Other (specify)     | \$ _____        | \$ _____        | \$ _____        | \$ _____        |
| <b>TOTAL/MONTH:</b> | <b>\$ _____</b> | <b>\$ _____</b> | <b>\$ _____</b> | <b>\$ _____</b> |

**\*\* IF MORE THAN 4 PERSONS IN HOUSEHOLD, PLEASE LIST ADDITIONAL NAMES AND INCOMES ON REVERSE SIDE.**

**WAIVER OF LIABILITY**

The undersigned applicant, on behalf of the applicant and the applicant's heirs, administrators, and assigns, hereby acknowledges and agrees that Southwest Michigan Rehab Foundation has no responsibility for the application of any funds granted applicant or for the quality of any services or products obtained with any grant, and applicant hereby releases Southwest Michigan Rehab Foundation from any and all liability whatsoever arising from or in any way related to the grant request or the services and products obtained by applicant. I hereby certify that the above information is true and correct.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Please mail or fax completed application (with prescription and bids) to:***

**SOUTHWEST MICHIGAN REHAB FOUNDATION**

**P.O. Box 2050**

**BATTLE CREEK, MI 49016**

**PHONE: 269/288-8687**

**FAX: 269/969-0974**

**\*Therapist, nurse or social worker: Please provide your name & phone # :** \_\_\_\_\_

**\* Name of prescribing physician:** \_\_\_\_\_

*If more than 4 persons in the home, list additional information below:*

**MONTHLY HOUSEHOLD INCOME:**

|                 | Person #5 | Person #6 | Person #7 | Person #8 |
|-----------------|-----------|-----------|-----------|-----------|
| Name:           | _____     | _____     | _____     | _____     |
| Age:            | _____     | _____     | _____     | _____     |
| Take home wages | \$ _____  | \$ _____  | \$ _____  | \$ _____  |
| Social Security | \$ _____  | \$ _____  | \$ _____  | \$ _____  |
| Pension         | \$ _____  | \$ _____  | \$ _____  | \$ _____  |
| Child Support   | \$ _____  | \$ _____  | \$ _____  | \$ _____  |
| Other (specify) | \$ _____  | \$ _____  | \$ _____  | \$ _____  |
| TOTAL/MONTH:    | \$ _____  | \$ _____  | \$ _____  | \$ _____  |