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:_____

Medical diagnosis:_____

Equipment requested:_____

Number of other dependents living in household:_____ **(PROVIDE DETAILS ON REVERSE SIDE)**

MONTHLY INCOME - Include name and income of spouse/partner (if any) leaving in household.

	Applicant	Spouse/Partner (if any)
Name:	_____	_____
Age:	_____	_____
Take home wages	$_____	$_____
Social Security	$_____	$_____
Pension	$_____	$_____
Child Support	$_____	$_____
Other (specify)	$_____	$_____
TOTAL/MONTH:	$_____	$_____

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 654 **PHONE: 269/288-8687**
ADA, MI 49301 **FAX: 269/969-0974**

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

*** Name of prescribing physician:** _____ (Rev. 01/2024)

DEPENDENTS (IF ANY) LIVING IN HOUSEHOLD:

	Name	Age	Relationship to Applicant
Person 1:	_____	_____	_____
Person 2:	_____	_____	_____
Person 3:	_____	_____	_____
Person 4:	_____	_____	_____
Person 5:	_____	_____	_____
Person 6:	_____	_____	_____