PROJECT MEND
INTAKE APPLICATION

☐ DURABLE MEDICAL EQUIPMENT SERVICE ☐ FITTED MOBILITY SERVICE

DATE		REFERRED BY	
NAME	COUNCIL DIST. #	PRECINCT#	
ADDRESS	COUNTY		
CITY	STATE	ZIP CODE	DATE OF BIRTH AGE:
TELEPHONE		SOCIAL SECURITY #	
DIAGNOSIS	MR #	HEIGHT	WEIGHT

CLIENT DEMOGRAPHICS *(Please check appropriate box)*

GENDER	Male	☐
	Female	☐
	Female Head of Household	☐
VETERAN, MILITARY PERSONNEL, FAMILY MEMBER	YES	☐
	NO	☐
AGE GROUP	0-18	☐
	19-34	☐
	35-59	☐
	60+	☐
ETHNICITY	White/Anglo	☐
	Hispanic/Spanish	☐
	African American/Black	☐
	A.Indian/Eskimo/Aleut/Othr	☐
INSURANCE	Medicaid	☐
	Medicare	☐
	County Hospital (CARELINK, GOLD CARD, NUECES AID, etc.)	☐
	Veteran's Insurance	☐
	Private Insurance	☐
	None	☐
LIVING ARRANGEMENTS	Alone	☐
	W/ Spouse	☐
	W/ Family	☐
	W/ Non-Family	☐
	Nursing/Retirement Facility	☐
	Homeless	☐

MONTHLY INCOME SOURCE(S)

VET, Military, Family: EXEMPT INCOME ☐

COSA CDBG: LIMITED CLIENTELE ☐

SSI / SSDI:________________

AFDC/TANF:________________

Child Support:________________

Family/Friends:________________

Wages/Salary:________________

Pension/Retirement: ________________

Other:________________

TTL Monthly Income:________________

Annual Income:________________

*****If ZERO income, Narrative *Required* on Income Certification Form*****

PROJECT MEND STAFF ONLY:
☐COSA-CDBG ☐Bexar County ☐JEREMIAH ☐Other Area (UT) ☐COASTAL BEND(UT)
☐ALAMO AREA (UT) ☐Children ☐Alcoa ☐Greehey

Updated: 03/17/2010

SERVICE AGREEMENT

Project MEND agrees to provide ________________ the refurbished equipment listed below to assist you in increasing your mobility needs that have been identified by your doctor.

Item ID	Equipment	Size	Quantity	Inventory Number	Donation	Date of Issuance

Conditions of the Service Agreement:

By signing this agreement and accepting the issued equipment you agree to: **(Please initial the following)**

_____Keep the equipment at the address you have provided and to notify Project MEND of your new address and phone number should you move or should your phone number change.

_____Be responsible for any repairs and maintenance to the equipment after the 30 day expiration date.

_____That you will not transfer/loan or give this equipment to any other person or allow any other person to use this equipment which has been deemed a medical necessity by your physician.

_____Use the equipment as your doctor has recommended for medical purposes or rehabilitation.

_____Use the equipment in the manner recommended by the original manufacturer of the equipment.

_____Accept full responsibility and indemnify and hold harmless Project MEND and its partner agencies against all claims, costs, expenses, damages and liability resulting from or pertaining to the use or operation of the equipment during the term of this agreement while you use this equipment.

_____I acknowledge that I have received printed instructions for the issued equipment.

_____I understand that the equipment I am receiving from Project MEND has been donated and therefore does not come with any manufacturer warranties or guarantees.

_____Recipient acknowledges that the equipment is in good working condition and that he/she has examined the equipment to inspect its condition and identify any defects.

_____I have read and understand that this is a service agreement and not a contract for sale or purchase of this equipment.

Client/Representative:____Date:______

Project MEND Staff:____Date:______

PROJECT MEND Staff ONLY:

Original Intake Date:__________ **Original Grant:**____________ **Current GRANT:** ____________________

EQUIPMENT POLICIES & FEES

(Effective September 1, 2009 the following fees apply to all clients completing an application for services)

PROCESSING FEE
A *$20.00* processing fee will apply to all clients completing an application for services.

30 DAY REPAIR POLICY
Project MEND will repair or replace all DME from the **original** date of intake up to this ***30 day expiration date***: ______.
After the above 30 day expiration date, all clients are responsible for the Standardized Repair Fee of $50.00.

ELECTRIC HOSPITAL BEDS
Project MEND will issue only **one** *Electric Hospital Bed* **once every 12 months**. The 30 day repair and replacement policy will apply towards any and all items related to the *Electric Hospital Bed* including but not limited to: Bed frame, Bed rails, Mattress, and Controller.

ELECTRIC WHEELCHAIRS AND SCOOTERS
Project MEND will issue only **one** *Electric Wheelchair* or *Scooter* **once every two years**. The 30 day repair and replacement policy will apply towards any and all items related to *Electric Wheelchairs* and *Scooters.*

BATTERIES
Electric Wheelchairs and Scooters are issued with a set of brand new batteries. Clients are responsible for the purchase of these batteries. These fees vary and are based on battery size/model.

12v, 12amp = $34.00 each	*12v, 18amp = $43.00 each*	*8AU1 = $64.00 each*	*8AU22NF = $105.00 each*

REPAIRS (Within Bexar County Only) Project MEND only repairs medical equipment that has been issued from our warehouse.
Standardized Repair Fee: $50.00

DELIVERIES (Within Bexar County Only)
Inside Loop 1604: $25.00
Outside Loop 1604: $50.00

ALL FEES ARE SUBJECT TO CHANGE.
Additional fees for all deliveries outside of Bexar County will be calculated based on distance and travel time. Please contact our office for rates.

Client/Representative:______________________________ Date:__________

Project MEND Staff:______________________________ Date:__________

WAIVER AND RELEASE OF LIABILITY

I, ________________________ have carefully read and understand that by signing this agreement, EXEMPT and RELEASE
(PRINT NAME)
PROJECT MEND and COLLABORATING PARTNERS and ALL RELATED ENTITIES FROM ALL LIABILITY OR PERSONAL RESPONSIBILITY WHATSOEVER FOR PERSONAL INJURY, PROPERTY DAMAGE, OR WRONGFUL DEATH AS A RESULT OF ACCEPTING AND RECEIVING DONATED, DISTRIBUTED, OR REPAIRED EQUIPMENT, HOWEVER CAUSED, INCLUDING, BUT NOT LIMITED TO PRODUCT LIABILITY OR NEGLEGENCE OF THE RELEASED PARTIES, WHETHER PASSIVE OR ACTIVE.

______________________________ ______________________
Client/Representative Date

______________________________ ______________________
Project Mend Staff Date

INCOME ELIGIBILITY CERTIFICATION

Client Name____

1. I do hereby certify that I have provided, to the best of my knowledge, the total gross annual income received during the past 12 months required to determine eligibility to participate in any Project MEND related program. $__________________, annually. ***I understand that information in regards to my gross income is necessary to determine eligibility.***

2. Including yourself, how many persons live in your household? ______________________.

Client or Representative **(Relationship to Client)** **Date**

Project MEND Staff Signature **Date**

FY 2009 Income Limit Area	FY 2009 Income Limit Category	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
	Very Low (50%) Income Limits	$20,000	$22,900	$25,750	***$28,600***	$30,900	$33,200	$35,450	$37,750
Bexar County	Extremely Low (30%) Income Limits	$12,000	$13,700	$15,450	***$17,150***	$18,500	$19,900	$21,250	$22,650
	Low (80%) Income Limits	$32,050	$36,600	$41,200	***$45,750***	$49,400	$53,050	$56,750	$60,400

NOTE: Bexar County is part of the **San Antonio, TX HUD Metro FMR Area**. The **San Antonio, TX HUD Metro FMR Area** contains the following areas: Bandera County, TX ; Bexar County, TX ; Comal County, TX ; Guadalupe County, TX ; and Wilson County, TX . Income Limit areas are based on FY 2009 Fair Market Rent (FMR) areas. For a detailed account of how this area is derived please see our associated FY 2009 Fair Market Rent documentation system.

IF NO INCOME, PROVIDE SELF CERTIFICATION OF FINANCIAL SUPPORT:

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MEDIA RELEASE STATEMENT

By my signature on this form, I acknowledge receipt of this document and give permission to Project MEND and its designee to use such reproductions for educational and publicity purposes in perpetuity without further consideration from me.

I understand that I will need to notify Project MEND if any changes to my situation occur that will impact this media release permission.

I have read the above release and am aware of its contents.

Signed: ____Date ______________

Print Name: ____

Address: ____

Phone: ______________________________Email: ______________________

☐ **CLIENT DENIED MEDIA RELEASE**