

For Office Use:  
Date Completed  
Application  
Received In  
The Office



## APPLICATION FOR THE MEDICAL ADAPTIVE/ASSISTIVE TECHNOLOGY PROGRAM

Recipient Name		Social Security Number		Date of Birth / /	
Address			City/State/Zip		
Home Telephone	Mobile Number		Employed? Yes No	Work Telephone	
<b>CONTACT INFORMATION</b>					
Contact Name		Relationship	Telephone	Cell	
Address			City/State/Zip		
<b>MEDICAL INFORMATION</b>					
Height _____	<b>Explain Medical Need And Equipment Requested</b>				
Weight _____					
<b>Comments/Referrals</b>					
Medical Insurance? Yes No	Name of Carrier		Medicare? Yes No	Medicaid? Yes No	
Did you attempt to get this equipment through your Insurance? Yes No If no, what is the reason? If yes, what was the outcome?					
Name of Doctor		Address		Telephone	
<b>REFERRAL INFORMATION</b>					
Referral? Yes No	Name		Title		
Organization & Location				Telephone	
<b>IDENTIFICATION</b>					
Picture ID: License #		Other ID & Type			
<b>TO BE SIGNED ONLY AT THE TIME OF EQUIPMENT DELIVERY</b>					
Equipment Received				Date Equipment Received	
Responsible Party Signature x			Verified By x		

**6301 Midlothian Turnpike  
Richmond, VA 23225  
Fax Number (804) 521-0595  
Telephone (804) 521-4916 or (804) 521-4923**

LAST  
NAME: \_\_\_\_\_

**A. INCOME PER YEAR**

\$

**B. INCOME SOURCE**

- 101 Family Support
- 102 Retirement/Social Security
- 103 Wages, Salaries
- 104 Welfare
- 105 SSI
- 106 Worker's Comp
- 107 Disability Ins.
- 108 Unemployment

**C. NATIONAL ORIGIN**

- 101 Alaska Native
- 102 American Indian
- 103 Arabic
- 104 Asian
- 105 Black or African American
- 106 Hispanic or Latino
- 107 Native Hawaiian
- 108 Pacific Islander
- 109 White Caucasian
- 110 Other (specify)  
\_\_\_\_\_

**D. LANGUAGE**

- 101 Arabic
- 102 Cantonese
- 103 English
- 104 French
- 105 Japanese
- 106 Korean
- 107 Russian
- 108 Sign Language
- 109 Spanish
- 110 Vietnamese
- 111 Other (specify)  
\_\_\_\_\_

**E. DO YOU NEED A RAMP**

(For survey purpose only)

- 101 Yes
- 102 No

**F. ARE YOU A VETERAN**

- 101 Yes
- 102 No

**G. EDUCATION**

- 101 High School Diploma
- 102 GED
- 103 Associates Degree
- 104 Bachelor's Degree
- 105 Master's Degree
- 106 Doctor's Degree
- 107 Special Education Certificate
- 108 Highest Grade Completed  
(Specify) \_\_\_\_\_

**H. TRANSPORTATION**

- 101 Family/Friends
- 102 Own Auto
- 103 Public
- 104 Specialized
- 105 Other (specify)  
\_\_\_\_\_

**I. LIVING ARRANGEMENTS**

- 101 Dependent
- 102 Homeless
- 103 Independent
- 104 Institution
- 105 Group/Adult Home
- 106 Other (specify)  
\_\_\_\_\_

**J. MARITAL STATUS**

- 101 Single
- 102 Married
- 103 Divorced
- 104 Widowed
- 105 Separated

**K. SEX**

- 101 Male
- 102 Female

**L. COUNTY OR CITY**

**M. WILL THIS EQUIPMENT HELP YOU WITH**

- 101 Education
- 102 Employment
- 103 Community Living

**N. PUBLIC OFFENDER**

- 101 Yes
- 102 No

**O. REHABILITATION HISTORY**

- 101 None
- 102 Prior Goodwill Services during Current Year

If Yes to Prior Goodwill Services, state which programs \_\_\_\_\_  
\_\_\_\_\_

- 103 Prior Services Elsewhere

- 104 Unknown

**P. DISABILITY**

- 101 AIDS/HIV
- 102 Arthritis/Rheumatic
- 103 Blindness/Visual
- 104 Cancer
- 105 Cardiac & Pulmonary
- 106 Cerebral Palsy
- 107 Deafness/Hearing
- 108 Diabetic
- 109 Epilepsy/Seizure
- 110 Kidney Failure
- 111 Learning Disability/ADD
- 112 MD
- 113 MS
- 114 Mental Retardation
- 115 Mental Health
- 116 Mobility/Orthopedic
- 117 Neurological Disorders
- 118 Spinal Cord Injury
- 119 Substance Abuse
- 120 Traumatic Brain Injury
- 121 Other (specify)  
\_\_\_\_\_  
\_\_\_\_\_

**Q. PRE-REFERRAL STATUS**

- 101 Incarcerated
- 102 Institutionalized
- 103 Never worked
- 104 Retired
- 105 Student
- 106 Underemployed
- 107 Unemployed