



Application for Durable Medical Equipment

Date: _____

1. Have you tried to obtain the DME through other sources? _____ Yes _____ No

2. How did you hear about us? _____

2. Why were you unable to obtain the DME through other sources? _____

Name _____ Birthdate: _____ Age _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Email: _____

Monthly Income: _____ Height/Weight: _____

Item(s) requested: _____

The equipment will be used for me or my family member's personal use and will not be sold to all the best of my knowledge all the information is true and accurate. I understand not all accessories may be available with the DME and may require contacting someone other than Saving Our Seniors at my cost.

Applicant Signature: _____ Date: _____

Please Return form by fax: 727-499-6783, Email: director@savingourseniors.care
mail to: 740 4th St. N #306 St. Petersburg, FL 33704.