TOBY CHURCHILL
Manufacturer of the Lightwriter®

Client Funding Form

Client Information

First name ..... Last name .....

Street address .....

City..... State..... Zip code .....

Place of residence:

Home ..... ☐ Group home..... ☐ Assisted living ..... ☐ Hospice program ..... ☐ Custodial care facility ..... ☐

Intermediate care/MR facility . ☐ Skilled nursing facility/Nursing facility..... ☐ Other (specify).....

Telephone number ..... Social Security number .....

Birth date (MM/DD/YYYY) ..... Sex ..... M ☐ F ☐

Status (tick all that apply):

Single..... ☐ Married..... ☐ Employed ..... ☐ Full time student..... ☐ Part time student..... ☐

Email address .....

Patient medical diagnosis..... Date of onset.....

Secondary diagnosis (if applicable).....

Is diagnosis result of an accident? ..... Y ☐ N ☐ If yes, date of accident .....

Type of accident:

Automobile/Motorcycle ..... ☐ Employment..... ☐ Other (specify).....

Does the client currently own a speech generating device? ..... Y ☐ N ☐

Has the client previously owned a speech generating device?..... Y ☐ N ☐

If yes, device name ..... Date of purchase .....

Parent/Guardian/Client advocate information

First name ..... Last name .....

Street address .....

City..... State..... Zip code .....

Telephone number ..... Emergency/Alternative number* .....

Email address .....

Relationship to patient:

Parent ..... ☐ Spouse..... ☐ Legal Guardian..... ☐ Other (specify) .....

*Should be different from home phone, please check here if not available ☐

Speech Pathologist/Evaluator information

First name ..... Last name .....

Facility name .....

Street address .....

City ..... State ..... Zip code .....

Telephone number ..... Fax number .....

Email address .....

State License number ..... ASHA number .....

Treating Physician information

First name ..... Last name .....

Practice name .....

Street address .....

City ..... State ..... Zip code .....

Telephone number .....

Medicaid provider number (if applicable) ..... NPI number .....

Insurance information

(All insurance coverage must be listed. Missing information will result in processing delays. Please mark N/A to those not applicable)

Medicare ID number ..... Is this a Medicare Managed Care? ..... Y ☐ N ☐

Name of Managed Care Organisation .....

Medicaid ID number ..... Is this a Medicaid Managed Care? ..... Y ☐ N ☐

Name of Managed Care Organisation .....

Insurance: Name .....

Policy holder information:

Name ..... Date of birth .....

Social Security number ..... Employer name .....

Group number ..... Policy number .....

Policy holder relation to patient:

Self ..... ☐ Spouse ..... ☐ Parent ..... ☐ Other (specify) .....

Insurance information:

Street address .....

City ..... State ..... Zip code .....

Telephone number ..... Case Manager (if applicable) .....

Secondary (Other) insurance: Name .....

Policy holder information:

Name ..... Date of birth .....

Social Security number ..... Employer name .....

Group number ..... Policy number .....

Policy holder relation to patient:

Self ..... ☐ Spouse ..... ☐ Parent ..... ☐ Other (specify) .....

Insurance information:

Street address .....

City ..... State ..... Zip code .....

Telephone number ..... Case Manager (if applicable) .....

****Please attach a copy of the front and back of all insurance cards****

Equipment requested

Product name/Number	Price
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Shipping information

First name ..... Last name .....

Street address .....

City..... State..... Zip code .....

Telephone number .....

Please note: AbleNet, Inc. cannot ship to a P.O. address.
MEDICARE & NEW YORK MEDICAID FUNDED DEVICES MUST BE SHIPPED TO THE CLIENT'S HOME ADDRESS.

Send completed funding package to:

AbleNet, Inc.
2625 Patton Road
Roseville, MN 55013

For assistance in completing this form, please call 1-800-322-0956

Signature(s) of Person(s) completing this form

By signing this form I verify that all the information on this form is correct and true to the best of my knowledge. I also understand that that information will be used by AbleNet, Inc. for the purpose of obtaining funding and hereby give permission to AbleNet, Inc to release this information as required by the funding sources listed within.

Signature:

Printed name .....

Date .....

Signature:

Printed name.....

Date .....