Department of Integrated Services For Individuals with Disabilities

Dipåttamenton Prugrama Para I Maninutet

Lourdes A. Leon Guerrero
Governor

Joshua F. Tenorio
Lieutenant Governor

Michelle L.C. Perez
Director

Reuel C. Drilon
Acting Deputy Director

ASSISTIVE EQUIPMENT APPLICATION

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

A. CLIENT IDENTIFICATION

Last Name	
First Name	
Middle Name	
Email Address	
Current Client of DISID	Yes ☐ No ☐
Insurance (specify)	Yes ☐ No ☐
Homeless	Yes ☐ No ☐

WHEELCHAIR - 18"	☐	ROLLATOR WALKERS	☐
WHEELCHAIR - 20"	☐	HEAVY DUTY SHOWER CHAIRS WITH BACK	☐
WHEELCHAIR - 22"	☐	ADJUSTABLE OVERBED BEDSIDE TABLES	☐
WHEELCHAIR - 24"	☐	FOLDING CANES WITH SEAT	☐
WALKING CANE -QUAD	☐	WHEELCHAIR RAMPS 3"	☐
	☐	HANDRAILS	☐

Home Address	
Mailing Address	
Contact Number(s)	

B. REQUIRED DOCUMENTS

Photo ID	☐ Power of Attorney (if applicable)
Doctor's Certification	☐ Other:

C. CLIENT CONTACTS

Primary Emergency Contact

Relationship	
Address	
Phone	
Email	

Physician Contact

Physician Type	

138 East Marine Corps Drive
Jones Guerrero Commercial Plaza, Suite C101
Hagatna, Guam 96910

Address				
Phone				
Email				

D. CLIENT DEMOGRAPHICS

Date of Birth			Age	
Gender	☐ Male	☐ Female		Prefer Not to Answer
Disability	☐ Permanent		☐	Not Applicable (N/A)
Physical Disability	*(Specify)*			Not Applicable (N/A)
Intellectual Disability				
Citizenship *(Specify)*				
Race *(Specify)*	☐ White			
	☐ Black/African American			
	☐ American Indian/Alaskan Native			
	☐ Asian			
	☐ Native Hawaiian/Other Pacific Islander			
	☐ Other			

"I UNDERSTAND, AS A PERMANENT RESIDENT OF GUAM, THAT THE EQUIPMENT I AM RECEIVING IS A DONATION AND NOT FOR SALE. I AM AWARE THAT THE EQUIPMENT IS NEW AND UNUSED, AND THAT DISID IS NOT RESPONSIBLE FOR ANY PERSONAL INJURIES (INCLUDING DEATH), PROPERTY LOSSES, MAINTENANCE, OR ANY DAMAGE RELATED TO THE EQUIPMENT GIVEN."

I HEREBY AUTHORIZE THE DISCLOSURE AND RELEASE OF THIS INFORMATION FOR THE PURPOSES INTENDED BASED ON THE DONATION AGREEMENT BETWEEN DISID AND THE DONOR.

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE (AR)	
DATE	
RELATIONSHIP TO THE CLIENT, if AR	

FOR DISID USE ONLY (PRINT/SIGN/DATE)

CONTROL#: ________________________

DISID REPRESENTATIVE	DATE
DISID DIRECTOR OR AUTHORIZED PERSONNEL	DATE

E. PHYSICIAN'S DISABILITY CERTIFICATION FOR ASSISTIVE EQUIPMENT

Name: ______________________________

Date of Birth: ____________ Contact No: ______

PHYSICIAN'S USE ONLY

A physician has determined that the named individual has met one or more of the categories below stated in the Americans with Disabilities Act (ADA) definition of an "individual with disability (ies)" in accordance to the ADA disability criteria.

______ Has a physical and/or mental impairment that substantially limits one or more of the major life activities of the individual.

______ Has a record of such impairment: and/or

______ Be regarded as having such an impairment

Disability: ______________________________

Date of Disability: ______________________________

The above individual has a PERMANENT mobility impariment(s) that warrant the use of Assistive Equipment.

☐ Yes ☐ No

Name of Physician: ______________________________

Address: ______________________________

____

Physician's Signature: __________________ Date: ______

Physician or Clinic Stamp:

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Hagatna, Guam 96910

PERSONAL STATEMENT FOR RECEIVING ASSISTIVE EQUIPMENT (Voluntary)

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