CANDIDATE INTAKE APPLICATION

DATE OF APPLICATION: _______________

CANDIDATE'S INFORMATION

NAME:			**GENDER:**
DATE OF BIRTH:	**CITY/STATE/COUNTRY OF BIRTH:**		
IS THE CANDIDATE A US CITIZEN? _____ YES _____ NO : LEGAL RESIDENT? ____ YES ____NO ____N/A			
DIAGNOSIS:			
RESIDENTIAL ADDRESS:			
Apt/Unit:	**CITY:**	**STATE:**	**ZIP:**
Is this also your Mailing Address: ____**YES** ____**NO:**			

<u>Race/Ethnicity</u>: *Mobility Angels Corporation will not discrimminate. We collect this information for the sole purpose of collecting demographical data for grants. If you do not wish to, you do not need to answer this section.* *CHECK ALL THAT APPLY:*

____ White	____ Native American	____ South American	____ Hawaiian/Pacific Islander
____ Black	____ Alaskan Native	____ Central American	____ Spanish Origin
____ Hispanic	____ Indian	____ Carribean/Bahamian	
____ Asian	____ Middle Eastern	**OTHER:**	
____ Multi-Racial	____ European		

CANDIDATE'S PRIMARY PHYSICIAN:

Primary Physician:		SPECIALTY:
ADDRESS:	OFFICE#:	FAX#:

INSURANCE INFORMATION:

PRIMARY INSURANCE:		Policy Holder:	
Member#:		Group #:	
SECONDARY INSURANCE:		Policy Holder:	
Member#:		Group #:	

NURSE CASEMANAGER NAME:	Phone #:
DOES THE RECIPIENT HAVE MEDICAID WAIVER? ____NO ____YES #:	
MEDICAID WAIVER/OTHER CASE MANAGER NAME/PHONE #:	

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PARENT/GUARDIAN #1:

NAME:	RELATIONSHIP TO CANDIDATE:
HOME PHONE #:	CELLPHONE#:
WORK #:	May we contact you via Text messaging? ____YES ____NO
EMAIL:	May we contact you via EMAIL? ____YES ____NO
EMPLOYER NAME:	How Long Have you Worked there?
EMPLOYER ADDRESS:	OCCUPATION:
Gross Yearly Income:	May we contact your employer to verify? ____ YES ____NO
Does Parent/Guardian #1 Reside with Candidate? ______ YES _____NO	
ADDRESS:	

PARENT/GUARDIAN #2:

NAME:	RELATIONSHIP TO CANDIDATE:
HOME PHONE #:	CELLPHONE#:
WORK #:	May we contact you via Text messaging? ____YES ____NO
EMAIL:	May we contact you via EMAIL? ____ YES ____NO
EMPLOYER NAME:	How Long Have you Worked there?
EMPLOYER ADDRESS:	OCCUPATION:
Gross Yearly Income:	May we contact your employer to verify? ____ YES ____NO
Does Parent/Guardian #1 Reside with Candidate? ______ YES _____NO	
ADDRESS:	

Are the Parents: _____ Married _____ Divorced ______ Legally Separated ______Other

OTHER DEPENDENT INFORMATION:

NAME:	RELATIONSHIP TO CANDIDATE:
AGE:	ANY DIAGNOSIS/DISABILITY:
NAME:	RELATIONSHIP TO CANDIDATE:
AGE:	ANY DIAGNOSIS/DISABILITY:
NAME:	RELATIONSHIP TO CANDIDATE:
AGE:	ANY DIAGNOSIS/DISABILITY:

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OTHER SOURCES & AMOUNT OF YEARLY INCOME:

SOURCE: AMOUNT: _____ MONTHLY ______ YEARLY

SOURCE: AMOUNT: _____ MONTHLY ______ YEARLY

PLEASE SELECT WHAT YOUR NEEDS ARE: (SELECT ONLY 1 CHOICE)

__________ MINI-VAN WITH WHEELCHAIR LIFT

WHEELCHAIR LIFT ONLY (CONVERT EXISTING VAN)

HAVE YOU STARTED/PLAN TO START YOUR OWN FUNDRAISING EFFORTS (GoFund Me or other)?

_____ NO ______ YES

If YES, how much have you raised/plan to raise?

WHAT IS THE CURRENT CAR YOU ARE USING FOR TRANSPORTING YOUR CHILD? _____ N/A

MAKE: MODEL: YEAR:

WHAT IS THE CAR INSURANCE POLICY? MONTHLY PREMIUM?

HOW DID YOU HEAR ABOUT MOBILITY ANGELS?

ARE YOU A FIRST TIME APPLICANT? _____ YES _____NO PREVIOUS DATE/S APPLIED:

PLEASE TELL US HOW A VEHICLE WITH A WHEELCHAIR LIFT WILL HELP YOUR FAMILY?

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My signature below ATTESTS and/or AUTHORIZES to the following:

▪ I certify the above information is correct to the best of my knowledge. If there are any changes, I will contact MOBILITY ANGELS CORPORATION to inform them of such.

▪I have provided a valid Driver's License and the front and back of the Candidate's insurance card.

▪I authorize MOBILITY ANGELS CORPORATION to contact my Medical Insurance company to verify eligibility and coverage for an electric wheelchair lift and minivan conversion.

▪I authorize MOBILITY ANGELS CORPORATION to contact nurse/case worker to verify medical diagnosis and eligibility for wheelchair lift/minivan conversion.

▪I authorize MOBILITY ANGELS CORPORATION to investigate my background for purposes of evaluating this Candidate Intake Application. I understand the Mobility Angels Corporation will utilize an outside firm to assist in checking such information.

▪I authorize MOBILITY ANGELS CORPORATION to verify employment status.

▪I agree to MOBILITY ANGELS CORPORATION's Privacy Policy which can be found on our website, www.moblityangels.org

PARENT/GUARDIAN #1 PRINT NAME:

SIGNATURE

PARENT/GUARDIAN #2 PRINT NAME:

SIGNATURE

OFFICE USE ONLY:

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