



Aplicación

_____ / _____ / _____
Su Nombre Seguro Social Fecha de Nacimiento

(____)____ - _____ M F _____ - _____
Teléfono Sexo Nombre de Contacto Relación Teléfono

_____ _____ _____ _____
Domicilio Ciudad Estado Código Postal

Raza: Blanco Negro Hispano Americ. Asiático Otro _____ S N
Nativo # de personas # de adultos Jefe de Familia
En familia

Quién le dijo de nosotros _____ Tiempo en NV _____ Doctor _____

Condición Medica _____

Aseguranza: Ningún Medicare Medicaid Privada/Otra _____

Empleado: Sí No Retirado Incapacitado Descansado Fecha de último empleo _____ Lugar _____

Ingreso mensual _____ (si el ingreso es mas de nuestra guia favor de llenar los gastos)

Gastos

Renta _____ Servicios Públicos _____ Transportación _____ Gastos medicos _____

Cuidado de niño _____ Comida y ropa _____ Tarjetas de credito _____ Otros _____

Total de gastos \$ _____ Cuánto le queda \$ _____



7910 N. Virginia St.
Reno, Nevada 89506
(775) 829-CARE
www.carechest.com

RELEASE/AGREEMENT

It is understood that the equipment received is the property of C*A*R*E* Chest of Sierra Nevada and is loaned at no cost to the patient for his/her comfort and use; this loan is subject to the following conditions:

- 1) The undersigned acknowledges that the information on this form is true and correct to the best of his/her knowledge and that all guidelines for C*A*R*E* Chest's program qualifications have been met. The undersigned agrees to notify C*A*R*E* Chest of Sierra Nevada of any change in status from that indicated on this form.
- 2) The undersigned acknowledges the equipment, supplies and services received have been used/may have been altered and hereby acknowledges receipt of same.
- 3) In consideration for the use of the equipment received, the undersigned on behalf of himself, his spouse, legal representatives, heirs and assigns, hereby releases, waives and discharges C*A*R*E* Chest of Sierra Nevada, its members, directors, officers and employees (hereinafter referred to as "Releasees") from all liability to the undersigned, undersigned's spouse, legal representatives, heirs and assigns for any and all loss or damage, and any claim or damages resulting there from, on account of injury to the undersigned or the undersigned's property, including but not limited to, injury resulting in death of the undersigned, whether caused by the negligence of Releasees or otherwise, resulting from the use of the equipment received. The undersigned agrees to indemnify the Releasees and each of them from any loss, liability, damage or costs (including attorneys' fees) that they may incur due to the loaning of the equipment received. The undersigned assumes full responsibility for the risk of bodily injury, death or property damage from the use of the equipment received. The undersigned agrees that this release is intended to be as broad and inclusive as permitted by the laws of the State of Nevada, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.
- 4) The undersigned hereby agrees to be responsible for the equipment received; if said equipment is misused, damaged or destroyed while in the patient's possession, the undersigned will take full responsibility for the reasonable cost of repairs or replacement.
- 5) The undersigned may borrow the equipment for as long as needed and agrees to return equipment promptly, in the same condition as received (except for normal and reasonable wear), as soon as the need no longer exists. The undersigned further agrees to return the equipment in clean condition.
- 6) Yes _____ No _____ The undersigned hereby grants permission to C*A*R*E* Chest of Sierra Nevada to release the patient's name and/or any relevant case information (which may include writings, photos, and/or biographical data) for the purpose of public education and awareness, promotion of services, solicitation of contributions, and/or any other constructive purpose in the furtherance of the objectives and purpose of C*A*R*E* Chest of Sierra Nevada

PATIENT SIGNATURE*

Date

* or designated responsible party if patient is unable to sign.

Print Name: _____
Phone: _____
DOB: _____
SSN: _____