



Application for Durable Medical Equipment

Date: \_\_\_\_\_

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

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

Name \_\_\_\_\_ Birthdate: \_\_\_\_\_

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](mailto:director@savingourseniors.care)  
Mail to: 752 24th Ave N St. Pete FL 33704.

Administrative Personnel Only:

Date order granted: \_\_\_\_\_ Cash/Check: \_\_\_\_\_

Inventory Number: \_\_\_\_\_