Client Information Form

This Client Information Form is used to facilitate the funding process through Forbes AAC, a trade name of Forbes Rehab Services. The information provided will be kept confidential. Please note that all requested information is necessary for Forbes Rehab Services to properly assist with the funding process. In order to ensure timely processing, please complete the ***entire*** Client Information Form. If you have any questions, please contact the Funding Department at 419.589.7866

email or **FAX completed form to:**

Forbes Rehab Services, Inc.
181 Illinois Ave. South
Mansfield, OH 44905
fax 419.589.5146
funding@forbesaac.com

Client Information – The client is the individual for which funding is being pursued.

Name _____ Phone _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ SSN _____

Sex ☐ Male ☐ Female

Have you applied for or are you receiving in home or facility based hospice care, skilled nursing care or hospital based care?

☐ No ☐ Yes

Have you ever owned a Speech Generating Device? ☐ No ☐ Yes, age of previous device

Place of Residence

☐ Home ☐ Group Home ☐ Nursing Home ☐ Long Term Care Facility Other _____

Evaluating Speech Pathologist – This is the SLP that completes the Evaluation and Speech Evaluation Report.

Name _____ Phone _____

Facility _____ Alt Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____ Email _____

Personal Advocate – This is an individual representing the client in a non-professional manner.

Relationship to client: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Email _____

Professional Advocate (Optional) – This is an individual representing the client in a professional manner.

Relationship to client: ☐ Assisting Speech Pathologist ☐ Case Manager ☐ Other

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Email _____

Forbes AAC
181 Illinois Ave. South
Mansfield, OH 44905

phone 419.589.7688
fax 419.589.5146

Referring Physician Information – This is the medical doctor who is prescribing the equipment.

Physician Name _____ Phone _____

Funding Sources / Insurance Coverage – Please indicate **all** funding sources/insurances that apply. **Include a clear copy of all ID cards (both front & back).**

☐ Medicaid / Medical Assistance Billing Number _____

☐ Medicare Billing Number _____

☐ Tricare / Military / Private insurance / HMO / Managed care program

☐ No ☐ Yes, complete Information below

Insurance company name _____

Case Manager or Contact Information (If applicable)

Name _____

Phone _____ Fax _____

Policy Holder's Information

Name _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____ Policy holder date of birth _____

Social Security Number _____ Policy Holder's SSN _____

Name of Employer _____ Policy/Contract ID # _____

Group # _____ Policy Holder Relationship to Client _____

Delivery or Shipment Contact – This is the contact for shipment and delivery of equipment (PO boxes not allowed)

*Medicare requires equipment to be shipped to Client's Residence

☐ Client ☐ Evaluating SLP ☐ Personal Advocate ☐ Professional ☐ Other (list below)

Contact Name _____ Advocate Phone _____

Address _____ City _____ State _____ Zip _____

Email Updates – The email addresses listed below will be included in funding email updates. If this section is left blank, all email address associated with the funding packet will receive updates.

Name & Relationship to Client _____ Email _____

Name & Relationship to Client _____ Email _____

Name & Relationship to Client _____ Email _____

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FORBES AAC
forbesaac.com

Notes –

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