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 | Fax

Funding Sources / Insurance Coverage – **BOTH Primary and Secondary insurance providers are required for funding. If both are not present at time of application it could significantly delay the funding approval process, and in many cases cause the process to start over. Both FRONT AND BACK of all cards need to be present to make sure the funding application is submitted correctly.**

Insurance Company Name

Policy Holder's Information - Primary

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

Insurance Company Name

Policy Holder's Information - Secondary

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

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FORBES AAC
forbesaac.com

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	

Notes –

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