DISABILITY DREAM WEAVERS

Application for Services

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Birth Date: _____

Marital Status (Please tick): Married ☐ Single ☐ Divorced ☐

Gender (Please tick): Male ☐ Female ☐ LGBTQ ☐

Social Security No: _____

Driver's License No: _____

Ethnicity: (Please tick)

- African American
- Asian
- Caucasian
- Chinese
- Filipino
- Greek
- Hawaiian/Pacific Islander
- Hispanic/Latin American
- Indonesian
- Italian
- Japanese
- Middle Eastern
- Vietnamese
- Others

Disability (Please circle any condition you currently have or have had in the past):

- Amputee
- Asthma
- Arthritis
- Autism Cancer
- Cerebral Palsy
- (COPD) Chronic Obstructive Pulmonary Disease
- Diabetes
- Epilepsy
- Gillian Barr Syndrome
- Heart Problem
- Hearing Loss/Deafness
- Hepatitis
- HIV/AIDS
- Kidney Stones/Renal Condition
- Lou Garrets Disease
- Lupus
- Mental Diagnosis
- Migraine Headaches
- Multiple Sclerosis
- Neuropathy
- Orthopedic Problem
- Parkinson's Disease
- Polio
- Spinal Cord Injury
- Quadriplegic/Paraplegic
- Stroke
- Tourette Syndrome
- Traumatic Brain Injury
- Vision loss/Blindness
- Other physical or mental condition (Pls describe):

  _____

  _____

Please describe your disability, physical condition, or emotional condition and how it affects your daily life.

_____

_____

_____

_____

_____

Do you consider the duration of your disability, physical condition, or emotional condition either temporary or permanent? (Please tick)

Permanent ☐ Temporary ☐

Disability Dream Weavers is a nonprofit organization that assists persons with disabilities in purchasing durable medical equipment and other essential items needed for daily living. Disability Dream Weavers will assist individuals in purchasing items such as:

- Wheelchair Accessible Cars and Vans
- Manual wheelchairs
- Power wheelchairs
- Walkers
- Scooters
- Canes
- Hearing Aids
- Computers and Accessories
- Kitchen Aids etc.

Please describe what type of equipment you currently need to assist you in your activities of daily living.

_____

_____

_____

_____

Insurance:

Please check the type of insurance you currently have:

Med-i-cal ☐

Medicare ☐

Private Insurance ☐

Are you a client of the State Department of Rehabilitation? (Please tick)

Yes ☐ No ☐

Counselor's Name: _____

Are you receiving Workman's Compensation? (Please tick)

Yes ☐ No ☐

Income:

What sources of income do you currently receive?

(Please check each source of income you currently receive and write in the total monthly amount.)

Social Security Supplemental Income (SSI)

Total Monthly Amount:_____

Social Security Disability Insurance (SSDI)

Total Monthly Amount: _____

Employment income
Total Monthly Amount: _____

Retirement income
Total Monthly Amount: _____

Other income
Total Monthly Amount: _____

Your Total Monthly Income is: _____

Any other comments/questions:

_____

_____

_____

_____