ASSISTIVE TECHNOLOGY LOAN AGREEMENT

OPTIONS for Independence (Logan Office) – 106 E 1120 N, Logan UT 84341
435-753-5353

A donation is suggested to help OPTIONS continue providing quality programs and services.
All information provided is kept strictly confidential by OPTIONS

PERSON ACTUALLY USING THE EQUIPMENT

Date: ____________________

Name: ____ Birth Date: ____/____/____ Age: ________

Address: ______________________________________ City: ____________________ Zip: __________

Telephone: ______________________________ MALE ☐ FEMALE ☐

Can you be contacted by text? ☐ Yes ☐ No # _________________________________

Disability: ☐ Physical/Orthopedic ☐ Cognitive ☐ Mental/Emotional
☐ Hearing ☐ Vision ☐ Other_____________

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino

Race: _____White _____American Indian or Alaska Native _____Asian
_____Black or African American _____Native Hawaiian or Other Pacific Islander

OTHER CONTACT INFORMATION (different than person actually using the equipment)

Name: ____ Telephone: ___________________________

Can you be contacted by text? ☐ Yes ☐ No # _________________________________

Address: ____ City: _____________ Zip: _________

EQUIPMENT LOANED

	Equipment Type & Condition	Inventory #	Returned (R) or Added (A)	Date Returned or Added
1.	E ☐ G ☐ F ☐ P ☐			
2.	E ☐ G ☐ F ☐ P ☐			
3.	E ☐ G ☐ F ☐ P ☐			
4.	E ☐ G ☐ F ☐ P ☐			
5.	E ☐ G ☐ F ☐ P ☐			

Deposit Amount Paid ________________ Date _________________ Cash ☐ or Check ☐ #____________

Deposit Returned Date_______________ Borrower's Signature of Return ________________________

How did you hear about OPTIONS' Loan Bank Program? ____

Are you registered to vote? YES ☐ NO ☐ If no, would you like assistance to register? YES ☐ NO ☐

LOAN POLICY

I understand that this equipment is to remain the property of OPTIONS for Independence and I agree to return it within 3 months from the original loan. I further understand it is my responsibility to keep this equipment in good repair and notify OPTIONS in the event the equipment becomes damaged or broken. I agree to assume financial responsibility for damage or loss of equipment that is incurred as a result of my neglect during the time I have this equipment. Replacement costs may include but are not limited to: repair, maintenance, or actual costs to replace the equipment. I also agree to return all equipment clean, or pay OPTIONS for the cost of cleaning - $10.

I understand that I may not make any structural modifications to this equipment. I agree not to hold OPTIONS or its employees liable for any losses, damages, or injuries incurred while using the borrowed equipment. I also agree to notify OPTIONS if I change my current address or telephone number.

This is to certify that I have borrowed the listed equipment from OPTIONS for Independence and I understand and agree to comply with all the policies and procedures pertaining to this equipment. I also understand that a Client Assistance Program Representative is available to act as my advisor and advocate, and that I may call toll free (800) 662-9080 or Salt Lake (801) 353-1347 to reach the Disability Law Center/Client Assistance Program (CAP), 205 North 400 West Salt Lake City UT 84103.

I further understand that services in this program are provided without regard to sex, race, age religion, color, national origin or disability according to Title VI of the Civil Rights Act, and Section 504, Rehab Act of 1973, as amended.

____ ____________________

Signature of Responsible Person Date Loaned

____ ____________________

OPTIONS' Representative Estimated Return Date

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OPTIONS for Independence relies on donations to assist people with disabilities. As a non-profit 501 (c)(3) tax exempt organization your donation may be tax deductible. Please retain a copy of this document for your records and follow up with your tax advisor. Thank you for your support!

Donation Amount Paid: $__________ Cash ☐ Card ☐ Check ☐ #_____________

INDEPENDENT LIVING PLAN

The purpose of an Independent Living Plan is to assist you to achieve independence through setting goals.

- ☐ I would like to develop an Independent Living Plan
- ☐ I waive my right to develop an Independent Living Plan

Goal: Information Access/Technology Date Set: ___________ Date Achieved: _____________

Objective: Acquire and utilize Assistive Technology loaned to achieve personal independence in home and/or the community on a short-term basis.

Possible Services:

Assistive Devices/Equipment ☐
Information & Referral ☐
Youth Services ☐
Preventative (prevent further injury) ☐
Children's Services ☐
Family Services ☐
Physical Restoration (pedal exercisers) ☐
Mobile Training (done with mobility devices only - by staff) ☐

Goal: Self Care Date Set: ___________ Date Achieved: _____________

Objective: To increase independence with respect to activities of daily living such as personal grooming and cleaning, toileting, etc. through the use of Assistive Technology loaned on a short-term basis.

Possible Services:

Assistive Devices/Equipment ☐
Information & Referral ☐
Youth Services ☐
Preventative (prevent further injury) ☐
Children's Services ☐
Family Services ☐

Will the services and supports received from utilizing OPTIONS' Loan Bank equipment prevent you from entering a nursing facility?

Yes ☐ **No** ☐ (if yes, a community-based living goal must be set)

Goal: Community-Based Living Date Set: ___________ Date Achieved: _____________

Objective: Acquire and utilize Assistive Technology loaned on a short-term basis to prevent the need of entering a nursing facility.

Possible Services:

Assistive Devices/Equipment ☐
Information & Referral ☐
Youth Services ☐
Preventative (prevent further injury) ☐
Children's Services ☐
Family Services ☐

Participation Statement: I have completed this Independent Living Plan I understand and accept it. I am committed to attaining the goals as outlined in the plan.

____ ____

Signature of Responsible Person Date OPTIONS' Representative Date

DEPOSIT POLICY

- Hospital Beds require a $100 deposit — Deposit Paid: Yes □ No □
- Foot or Leg rests for wheelchairs require a $25 deposit — Deposit Paid: Yes □ No □
- Knee Walkers require a $50 deposit — Deposit Paid: Yes □ No □
- Ramps require a $100 deposit — Deposit Paid: Yes □ No □

Deposits will be fully refunded if the item is returned by the due date in a clean working condition. If, however the item is returned in need of repairs, cleaning due to smoking, body fluids or any other reason, and/or not returned for any reason, the deposit will be kept to offset these costs. You may also be responsible for any additional charges OPTIONS incurs above and beyond the deposit due to negligence up to the full replacement cost of the item.

EQUIPMENT RETURN

□ I certify that I am returning the equipment loaned to me in clean, good working condition, OR

□ I certify that the equipment loaned to me is in need of repairs. I agree to work in conjunction with OPTIONS to obtain these repairs and to assume financial responsibility. Repairs needed:

____

____

____________________________________ ______________________

Signature of Responsible Person Date Returned

__________________________ ______________________

OPTIONS' Representative Date Returned

This form is to track efforts made by OPTIONS' staff to get overdue equipment returned or to monitor their independent living goal. It is to be attached to the original loan bank form when utilized.

MONITORING CALLS

1) Date: ____________________ Response: ____

2) Date: ____________________ Response: ____

3) Postcard Mailed: ____

REFERRAL TO IL SERVICES **(if this is a permanent or long-term need)**

IL Packet sent: _________________________ (date)

IL Packet returned: ______________________ (date)

The person borrowing the equipment is already a consumer: □ Yes □ No (if yes complete the next line)

His/her IL Coordinator is _____________________ and was made aware of this loan ______________ (date)

INVOICE(S) SENT

1) Date: ________________________ 2) Date: ______________________

Other notes: ____

____

____

AT SIGNED OVER

Item(s): ____(list)
was signed over to eligible consumer/borrower on ____________________ (date) with approval from _______________________ (staff signature). An equipment receipt must also be signed by the person receiving the equipment and attached to the original loan bank forms.

AT DISCHARGED

______________________________________ (staff signature), approved discharging the borrowed

equipment ____ as

unable to be returned after several unsuccessful attempts by OPTIONS' staff. The borrower has been placed on OPTIONS' "DO NOT LOAN" list.

Please make sure information from this page is also kept in CIL Suite.