

# Salttilo Client Information Form

## 1. CLIENT

The client is the person who will be receiving the equipment or services

Client Name (Last, First, MI):

Client Date of Birth:

Status:  Married  Single  Other  Employed  Full-Time Student  Part-Time Student

Sex:  Male  Female

Zip(where SSI pymts are sent):

Social Security Number:

Currently own a communication device?  Yes  No Make/Model:

Date of purchase:

Current place of residence:  Home  Skilled Nursing Facility  Nursing Facility  Custodial Care Facility  Assisted Living  
(check all that apply)  Group Home  Intermediate Care Facility/Mentally Retarded Facility  In Hospice Program

Address:

Name of Facility:

City:

State:

Zip:

County:

Home Phone: ( ) -

Work Phone: ( ) -

Fax: ( ) -

## 2. CONTACT / CLIENT ADVOCATE

The contact person is the person who is assisting the client, or is the emergency contact

Name:

Relationship to Client:  Spouse  Parent  Legal Guardian  Other (please specify)

Address:

E-Mail:

City:

State:

Zip:

Phone: ( ) -

Alternate Phone: ( ) -

Fax: ( ) -

## 3. SPEECH LANGUAGE PATHOLOGIST

The SLP is the clinician that performed the evaluation of the client and provided the written report

Name:

Address:

E-Mail:

City:

State:

Zip:

Phone: ( ) -

Alternate Phone: ( ) -

Fax: ( ) -

ASHA Number:

State License Number:

## 4. TREATING PHYSICIAN

The treating physician is the medical doctor who has prescribed the requested equipment

Name:

UPIN (Universal Personal ID Number):

Address:

City:

State:

Zip:

Work Phone: ( ) -

Alternate Phone: ( ) -

Fax: ( ) -

Medicaid Provider Number:

State License Number:

## 5. DIAGNOSIS

Client condition which requires requested equipment or services

Primary Diagnosis:

Diagnosis Code (ICD-9): .

Date of Onset:

Secondary Diagnosis:

Diagnosis Code (ICD-9): .

Date of Onset:

Is Diagnosis a result of an accident?  Yes  No

If yes: Date of accident?

Type of Accident?

Employment

Auto

Other

If Auto: Place (state)?

**6. PRIMARY INSURANCE**

If the Primary insurance is Medicare or Medicaid, just fill in the ID Number below and proceed to Secondary insurance

Type:  Medicare  Medicaid / Medical Assistance  CHAMPUS / Military Coverage  Private / Group  HMO

Name of Insurance: ID Number:

Contact Name: Contact Phone: ( ) - Contact Fax: ( ) -

Billing Address: State: Zip:

**Policy Holder / Insured**

Name: Phone: ( ) - Fax: ( ) -

Address: State: Zip:

Name of Employer: Employer Address: State: Zip:

Policy Number: Group Number: Social Security Number: - -

Relationship to Client:  Spouse  Parent  Legal Guardian  Other Date of Birth:

**7. SECONDARY INSURANCE**

If the Secondary insurance is Medicare or Medicaid, just fill in the ID Number below and proceed to Equipment

Type:  Medicare  Medicaid / Medical Assistance  CHAMPUS / Military Coverage  Private / Group  HMO

Name of Insurance: ID Number:

Contact Name: Contact Phone: ( ) - Contact Fax: ( ) -

Billing Address: State: Zip:

**Policy Holder / Insured**

Name: Phone: ( ) - Fax: ( ) -

Address: State: Zip:

Name of Employer: Employer Address: State: Zip:

Policy Number: Group Number: Social Security Number: - -

Relationship to Client:  Spouse  Parent  Legal Guardian  Other Date of Birth:

**8. EQUIPMENT RECOMMENDATION**

Complete list of all equipment, accessories, and parts requested.

Rental OR  Purchase

Qty	Part Number	Description	Price

**9. SHIPPING INFORMATION**

Phone number is required. Medicare funded devices must ship direct to client. **We cannot ship to a Post Office box.**

Name: Organization:

Address:

City: State: Zip: Phone: ( ) -