



65, rue Brunswick Street, Fredericton, N.-B., E3B 1G5

Tel: 506-458-8739
Fax: 506-457-2863
E-mail: info@easterseals.nb.ca
Web: www.easterseals.nb.ca

Application for AT Loan Program

1) APPLICANT'S INFORMATION:

Applicant's Name: _____ Medicare Number: _____

Address: _____ City: _____ Postal Code: _____

Tel #: Home: _____ Cell: _____ E-mail: _____

Date of Birth: ____ / ____ / ____ Next of Kin: _____ Relationship: _____
Day Month Year

Their Contact Information: Tel: _____ Cell: _____ Email: _____

Please indicate applicant's disability/disabilities:

- Hearing
- Vision
- Speech
- Mobility
- Intellectual
- Learning
- Mental Health
- Other (specify) _____

Does the applicant work with or receive assistance from an organization which serves persons with disabilities such as: *Ability NB, Neil Squire Society, CNIB, NB Deaf & Hard of Hearing, NB Association for Community Living, ALS, Muscular Dystrophy Association, or other agency?* Yes _____ No _____

Please provide details:

Does the applicant have access to a health care plan that would assist in covering the costs? YES ___ NO ___

Plan information

The cost of sourcing, procuring, refurbishing and shipping assistive technology is substantial. All applicants will be asked to contribute to the costs of their loan.

I can pay \$ _____ to Easter Seals NB to help cover the cost of my loan.

APPLICANT'S CONSENT

I, _____, the applicant, give my permission to share my personal information with another agency only as it pertains to processing my application.

Applicant's Signature: _____ Date: _____

2) SHIPPING INSTRUCTIONS:

PLEASE NOTE: ESNB WILL ONLY SHIP TO A CIVIC ADDRESS – NOT A PO BOX

Ship to: Name: _____ Telephone Number: _____

Street Address: _____ City: _____ Postal Code: _____

3) PROFESSIONAL RECOMMENDATIONS: Type of Loan:

- Trial (2 months or less)
- Long-Term



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3) PROFESSIONAL RECOMMENDATIONS:

ORDER SUMMARY

ITEM:	
DESCRIPTION:	
RATIONALE:	
ITEM:	
DESCRIPTION:	
RATIONALE:	
ITEM:	
DESCRIPTION:	
RATIONALE:	
ITEM:	
DESCRIPTION:	
RATIONALE:	

Referral Agent's Name: Please print: _____ Profession: _____

Referral Agent's Signature: _____ E-Mail: _____

Date: _____

Fax application to: ESNB- **FAX #: 1-506-457-2863**
Please ensure you retain a copy of the application for your records