7961 Falling Creek Rd
Bedford, Virginia 24523
Phone # (540) 425-0467
Fax # (540)-527-9837
Email: pspcbdfoundation@gmail.com

Application for Assistive Equipment

Name of Applicant:	Date of Birth:	Primary Contact #:
Primary Mailing Address:		
Person filling out the form:	What Is Your relation to Applicant:	Primary Contact #:
Primary Contact Email:	Primary Diagnosis related to application: ☐ PSP ☐ CBS ☐ CBD ☐ PSP and CBS/CBD	Has the applicant applied for assistance with us prior? ☐ Yes ☐ No

Assistive Equipment that is Requested:

_____

_____

Approximate Cost of Assistive Equipment Request:

$

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Reason for the request:

_____

_____

Please provide a receipt of assistive equipment purchase for expedited review.

Has Assistive Equipment been purchased and the applicant is applying for a reimbursement?

- ☐ YES
- ☐ NO

If the answer is no to the previous question, where are you purchasing the equipment from?

_____

Company

_____

Website

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*This application must be signed by a licensed professional member of your multidisciplinary care team. This can include a Registered Nurse, License Practicing Nurse, Nurse Practitioner, General Physician, Physical Therapist, Occupational Therapist, Speech-language Pathologist, Dietitian.

I testify that the person above is diagnosed with progressive supranuclear palsy and/or corticobasal syndrome and/or degeneration who may require assistive equipment as stated above to improve their quality of life.

Licensed Professional Signature Date

Licensed Professional Printed Name

NPI #:	Field of Expertise:
Contact #:	Email:

Signature of Applicant Printed Name
OR Individual filling out form

_____
Date

***Please allow up to 30 days for processing and approval of this application prior to contacting PSP&CBD Foundation to check the status of your application**.