Application for Durable Medical Equipment (DME)

Oklahoma ABLE Tech partners with The Oklahoma Health Care Authority (OHCA) to provide the Oklahoma Device Reuse Program. Priority will be given to SoonerCare members, but any Oklahoma resident is eligible.

Oklahoma Device Reuse Program
3325 N. Lincoln Blvd., Suite B, Oklahoma City, OK 73105
Phone: 405.523.4810  Fax: 405-523-4811

* Indicates Required Field

Name*
First Name
Last Name

Telephone*
Alternate Telephone

Please specify if the residence is an apartment or elderly living community with accurate room numbers or building numbers.

Address*
Address Line 1
Address Line 2
City
State
ZIP Code

Email*

Are you SoonerCare/Oklahoma Medicaid eligible?*
☐ Yes  ☐ No

Birthdate*

If yes, provide your SoonerCare/Oklahoma Medicaid

Are you completing this application for someone else?*
☐ Yes  ☐ No
Please select the equipment you're requesting * (you can choose multiple items):

- [ ] Bathtub Transfer Bench
- [ ] Bedside Commode
- [ ] BiPap *(Requires sleep study. Does not include masks, hoses, or filters)*
- [ ] Blood Pressure Monitor
- [ ] CPAP* *(Requires sleep study. Does not include masks, hoses, or filters)*
- [ ] Electric/Semi Electric Hospital Bed* *(Does not include a mattress)*
- [ ] Gait Trainer**
- [ ] Knee Walker
- [ ] Manual Wheelchair*
- [ ] Nebulizer* *(Does not include medication or tubing)*
- [ ] Patient Lift** *(Does not include slings)*
- [ ] Power Scooter**
- [ ] Power Wheelchair**
- [ ] Quad Cane
- [ ] Rollator Walker*
- [ ] Shower Chair
- [ ] Stander**
- [ ] Transport Wheelchair
- [ ] Walker*
- [ ] Other

* requires a prescription  ** Requires a prescription and evaluation report from ATP/OT/PT

If you chose "Other" - please list the device name here:

If you chose "Other" - please list the device name here:

Will the requested equipment need to be:*  
- [ ] Pediatric  - [ ] Adult  - [ ] Bariatric (over 250 lbs.)

If the equipment you need requires measurements, please complete the "Customer Measurement" section below.

Have you used this equipment before:?*  Will this equipment be the initial piece or a replacement:?*  
- [ ] Yes - [ ] No  - [ ] Initial  - [ ] Replacement

Do you have a prescription from your doctor for this equipment:?*  
- [ ] Yes  - [ ] No

If the equipment is required, can you provide the additional documentation?  
- [ ] Yes  - [ ] No

Please attach a copy of your prescription and/or evaluation report to this application.

If you have more than one prescription, you can attach or fax multiple prescriptions to: (405) 523-4811.
If you have any questions, please call our office at (405) 523-4810.
Does the recipient have insurance?
☐ Yes  ☐ No

If yes, please list

This device will benefit the person in...
☐ Education  ☐ Community Living  ☐ Employment  ☐ IT access/Telecommunications
☐ Other:

Ramp Information Survey
☐ I presently have a ramp to get into my home.  ☐ I need a ramp to get in my home.  ☐ I do not need a ramp to get in my home.
☐ Other:

CUSTOMER MEASUREMENTS

The purpose of customer measurements is to obtain rudimentary measurements to decrease the frequency of false deliveries. There are many websites available for instruction on how to obtain proper measurements. Please note that these measurements are not intended to guarantee appropriate assessment or fit. The person should be seated on a firm surface with feet flat. Provide body measurements, not chair measurements.

Height*  Weight*

Measurement: LAP WIDTH - REQUIRED FOR WHEELCHAIRS

Measure the hips at the fullest part. You can add up to 2 inches to the number depending on the amount of room the individual wants. If you were to place two books on either side of the hips, you would measure straight between the two books instead of curving up and over the lap like a seatbelt would.

Inches

Does the wheelchair need a seatbelt?
☐ Yes  ☐ No

Does the wheelchair need leg rests?
☐ Yes  ☐ No

Does the wheelchair need elevated leg rests?
☐ Yes  ☐ No
How did you hear about ABLE Tech?

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Preferred Delivery Method*

- [ ] Prefer to pick up and return at Oklahoma ABLE Tech (Stillwater, Tulsa, Oklahoma City)
- [ ] Prefer the device to be shipped during the work week from 8:00 am - 4:00 pm
- [ ] I am requesting a hospital bed or motorized wheelchair or live within 65 miles of Oklahoma City and prefer to have my item(s) delivered.

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I understand and agree that I am responsible for the proper handling, storage, use, care, maintenance, and return of the device(s), components(s), accessory(ies) loaned to me hereunder.

In the event that I lose or there is a malfunction of device(s), component(s), or accessory(ies), I shall immediately notify Oklahoma ABLE Tech at 1-800-257-1705 (toll-free).

In the event of a theft of the device(s), component(s) or accessory(ies), I will report the theft to the local law enforcement agency and provide a copy of that report to Oklahoma ABLE Tech.

I shall not pledge, assign, transfer, or otherwise give any interest in and to the device(s), component(s), and accessory(ies) to any third party not listed on the loan request form.

This equipment will be used for me or my family member’s personal use and will not be sold. To the best of my knowledge, all information is true and accurate. I understand not all accessories may be available with the DME and may require contacting someone other than OKDMERP at my own cost. When I no longer need the device(s) I am aware that I am responsible for returning any/all equipment to Oklahoma ABLE Tech.

*Applicant Signature or Authorized Representative

Signature*