Maryland Durable Medical Equipment Re-Use

Address:
11701 Crain Highway
Cheltenham, MD 20623
Phone: 240-230-8000
Fax: 240-230-8004
Website: dme.maryland.gov
Email: dme.mdoa@maryland.gov

Complex Equipment Request Form

Complete this form on paper and then mail, fax, or scan and email it to us.

*** Fields denoted with an "*" are required. Failure to provide this information will void your request.**
A number of people must be identified: 1) who is requesting the equipment ("Requestor"), 2) who will be the beneficiary of the equipment ("Beneficiary"), 3) who will pick up the equipment, and 4) who is the licensed health care professional ("Health Care Professional") approving the use of the equipment for the Beneficiary. The Requestor is the person completing and signing Part A of this form and who will be given ownership of the equipment. The Requestor, the Beneficiary, and the pick-up person may be three different people, two different people (for example, the Requestor and Beneficiary can be the same person while the person picking up is a second person), or one person.

There are three parts to this form: Parts A, B, and C. Part A must be filled out by the Requestor—the person requesting the equipment. Parts B and C must be filled out by a Health Care Professional treating the Beneficiary of the equipment.

Part A: This part must be completed, and the second page signed where indicated, by the person requesting the equipment.

Person Requesting ("Requestor") the Equipment		
First Name*	Last Name*	
Address*		
City*	State*	Zip*
Phone*	Email Address	

Person Picking Up Equipment (must be able to load and unload equipment independently)		
☐ Same as Requestor Information above		
First Name*	Last Name*	
Address*		
City*	State*	Zip*
Phone*	Email Address	

Collection and Protection of Personal Information

Requestor and the Health Care Professional are providing personal information (including, but not limited to, name, address, and date of birth) in this Request Form, and the Health Care Professional may be confirming the information. The purpose of requesting this personal information is to help operate, seek funding for, minimize costs of, and evaluate the Re-Use Program. Requestor, Beneficiary, and the pick-up person have a right to inspect, amend, or correct his/her personal information kept by the Program. The Program will not permit public inspection of the personal information, or make it available to others, except as permitted by Federal and State law.

Liability Waiver and Release Agreement:

This agreement is a release of all rights to sue for injuries or death resulting from the equipment received from the not-for-profit, state-operated **Maryland Durable Medical Equipment Re-Use (hereinafter "MDMER").** The person requesting the equipment (hereinafter "Requestor") hereby expressly assumes all risks related in any way to the use or appropriateness of the equipment. Requestor understands **MDMER: (i)** does not provide medical advice on the appropriateness of any durable medical equipment; (ii) does not provide delivery service or post-delivery assembly, and (iii) does recommend seeking advice of health professionals, such as physical therapists, occupational therapists, or nurse practitioners, before obtaining or using durable medical equipment. Requestor will examine the equipment to verify that the equipment is in good working order before the equipment is used to assist the beneficiary identified above (hereinafter "Beneficiary"). Requestor will read written and review video materials provided with the equipment and transmit the information contained therein to the Beneficiary and the Beneficiary's caregivers before the equipment is used. Requestor also understands that neither **MDMER** nor its officers, officials, agents, employees, or volunteers (hereinafter "Releasees") shall be held liable or responsible in any way for injury, death, or other damages to the Requestor, the Beneficiary, or the pick-up person, or their respective families, heirs, or assigns, that may result from or be related to in any way to the equipment, the use of the equipment, a product defect in the equipment, wear and tear of the equipment, or the passive or active negligence of any party, including the passive or active negligence of Releasees.

Requestor acknowledges that Requestor is accepting and taking ownership of the equipment "as is" and "with all faults," and acknowledges that **MDMER** has disclaimed all warranties. There is no warranty that the equipment will be fit for a particular purpose. Requestor acknowledges that Requestor assumes all risks resulting from the ownership and use of the equipment.

Requestor hereby releases, discharges, and agrees not to sue **MDMER** or any of the Releasees on account of any injury, loss, or damage of any kind (including, without limitation, death) to any person or property, caused directly or indirectly, or in any way arising out of the equipment, whether such injury or loss was caused or alleged to be caused in whole or in part by the passive or active negligence of the Releasees or otherwise.

Requestor shall hold harmless and indemnify the Releasees with respect to any claim of liability for any losses or damages allegedly caused by the equipment or its use.

MDMER MAY, IN ITS SOLE AND ABSOLUTE DISCRETION, DECLINE TO PROVIDE THE EQUIPMENT IF IT BELIEVES: 1) THE BENEFICIARY DOES NOT NEED THE EQUIPMENT OR 2) THE BENEFICIARY OR THE BENEFICIARY'S CAREGIVER(S) WILL NOT, OR WILL NOT BE ABLE TO, USE THE EQUIPMENT SAFELY.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND FULLY UNDERSTAND THE ABOVE LIABILITY WAIVER AND RELEASE AGREEMENT AND I AFFIRM UNDER THE PENALTIES OF PERJURY THAT, TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF: (1) ALL THE INFORMATION I PROVIDED ON THIS FORM IS TRUE AND ACCURATE, AND (2) THE EQUIPMENT WILL ONLY BE FOR PERSONAL USE AND NOT SOLD.

REQUESTOR'S Signature:	**Date:**
REQUESTOR'S Printed Name:	

Part B: This part requests information about the Beneficiary and must be filled out by the licensed Healthcare Professional treating the Beneficiary.

Equipment Beneficiary Information (must be a Maryland resident)			
First Name*	Last Name*		Date*
Street Address*			
City*	County*	State*	Zip*
Phone*	Email:		
Date of Birth*	Height*		Weight*
Beneficiary's Coverage (select all that apply): * ❑ Medicare ❑ Medicaid ❑ Private Insurance ❑ No Insurance	Why is DME not being purchased and paid for under the Beneficiary's insurance policy? *		

Part C: A licensed Health Care Professional treating the Beneficiary must complete this Part C.

Please select equipment (Subject to availability):

Mobility Items

Cane:
- ☐ Single Point
- ☐ Quad Small Base
- ☐ Quad Large Base

Crutches:
- ☐ Underarm
- ☐ Forearm

Walker:
- ☐ Standard (no wheels)
- ☐ Rolling (two wheels)
- ☐ Rollator

Bathing
- ☐ Shower Chair
- ☐ Shower Chair with Back
- ☐ Bathtub Transfer Bench

Toileting
- ☐ Bedside Commode
- ☐ Toilet Safety Rails

Transfers
- ☐ Transfer Board

Complex Equipment

Physician, PT, OT, PA, or CRNP ONLY
- ☐ Manual wheelchair
- ☐ Transport wheelchair
- ☐ Knee Scooter
- ☐ Semi/Electric Home Health Bed
- ☐ Patient (Hoyer) lift - sling not included
- ☐ Trapeze Bar

Physical/Occupational Therapist ONLY
- ☐ Power Wheelchair
- ☐ Power Scooter

Additional Information/Requests:	Optimal Wheelchair: Seat Width_____ Seat Depth_____ Joystick Left / Right

I am a licensed health care professional _____* [insert profession] treating the above named beneficiary/patient within my scope of practice. The requested equipment is appropriate for the beneficiary/patient, and [choose one]:

___ I or my staff will provide or have provided the necessary training on the identified equipment to the beneficiary/patient, their caregiver, or both,

OR

___ The beneficiary/patient or caregiver is able to use the equipment safely without additional training.*

Name*	Title*
License #*	Employer*
Phone*	E-mail Address*

Health Care Professional:

Signature_____* Date:_____*