"Creating A Better Tomorrow, Today"™

Funding Questionnaire

Beneficiary Information (The beneficiary is the recipient of the funding. No PO Box please for shipping reasons).

First Name________________ MI______ Last Name________________________________
Address____________________________ Phone #(_____)___________________________
____________________________ Date of Birth______________________________
City ____________________________ SSN#____________________________________
State _________Zip_______________ Sex: ☐Male ☐Female
Place of Residence? ☐Home ☐Group Home ☐Nursing Home ☐Long Term Care Facility
☐Other ___________________________ Facility Fax #(_____)______________________
Have you applied for or currently on Hospice? ☐No ☐Yes

Have you ever owned a Speech-generating Device?
☐No ☐Yes, attach invoice from old device.

Beneficiary Contact Information (Who could answer any questions we may have by phone?)
First Name _________________________ Last Name______________________________
Address if Different than above____
____
Home Phone # (_____)_________________ Work Phone # (_____)______________________
Fax # (_____)________________________
Relation to Beneficiary: ☐Spouse ☐Parent ☐Guardian ☐Other: _____________

Who Is Your Speech Therapist?
First Name_________________________ Last Name______________________________
Facility Name____
Address____
City________________________State________________Zip_________________________
Phone # (_____)____________________ Fax # (_____)____________________________

Required Documents
This is your checklist; we need all of the following documents sent to FRS, Inc.
- ☐ Completed Funding Questionnaire (this form)
- ☐ Clear and current copies of both sides of all insurance cards (Medicare, Medicaid, Private Ins. CHAMPUS)
- ☐ Signed Medicare Release and Assignment of Benefits Form
- ☐ Payment of Co-Pay and/or Deductible enclosed, (if applicable)