Main Office
7311 Martinsburg Pike
P.O. Box 1882
Shepherdstown, WV 25443

Phone: (304)876-3325
Fax: (304)876-1645

Good Shepherd Interfaith Volunteer

CAREGIVERS

A Faith in Action Program

MEDICAL EQUIPMENT LENDING FORM

*****FOR BERKLEY AND JEFFERSON COUNTY RESIDENTS*****

BUYER OR RECIPIENT AGREEMENT

******FOR USED MEDICAL EQUIPMENT ("AS IS" CONDITION)******

GSIVC sometimes finds that an excess of a specific type of donated, but used, medical equipment is creating a storage or space problem for the organization. In such a case, GSIVC may sell (for a nominal fee) or donate the item "as is", with no express nor implied warranties of safety and operation by GSIVC, Inc.

Those using any medical equipment should consult their physician or licensed health care provider prior to use, and use only as suggested by such person or persons. GSIVC, Inc. is not responsible for any injury incurred or damage caused by any use of such equipment.

Buyer or Recipient understands that the equipment has been previously used, may not operate properly, assumes all risk for the use of the equipment and further agrees to release GSIVC, Inc. from any and all liability related to use of the equipment.

Name: _____Date of Birth: _____

Mailing Address: _____

City: _____State: _____Zip: _____

Physical Address:_____

City: _____State: _____Zip: _____

General Location: _____

Sex: _____Ethnicity: _____

Home Phone: _____Other Phone: _____

Religion or Faith: _____

I HAVE READ AND AGREED TO BE A BUYER OR RECIPIENT:

Signature: _____Date: _____

ESTIMATED POVERTY LEVEL:

The following information is gathered for organizational and funding purposes only. All information will be kept confidential and will not affect your Care Receiver eligibility status or any services provided to you by Good Shepherd Caregivers.

INSTRUCTIONS FOR INDICATING YOUR POVERTY LEVEL STATUS:

One the table below, find the size of your family unit in the first column. Then look at the figure just to the right of your family unity size; this amount is 125% of the federal poverty level for your size family. If your household is below this amount, put a check mark in the box to the right of this amount. If your household income is above this amount, you should leave the box blank.

Size of family unit	125 Percent of Poverty	Check Box that Applies
1	$14,363	☐
2	$19,388	☐
3	$24,413	☐
4	$29,438	☐
5	$34,463	☐
6	$39,488	☐
7	$44,513	☐
8	$49,538	☐

****ACCORDING TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 2014 POVERTY GUIDELINES****

What is your income level: Above Average→☐ Average→☐ Below Average→☐

GSIVC has the "right to disclose" pictures and stories: Yes→☐ No→☐

Applicants Signature: _____Date: _____

PLEASE COMPLETE THE FOLLOWING PART OF THE FORM IF YOU ARE NOT THE PERSON TO RECEIVE CARE:

AGENCY OR INDIVIDUAL MAKING REFERRAL:

Name: _____Agency: _____

Relationship: _____Phone: _____

Address: _____City: _____State: _____Zip: _____