



## Request For North Dakota Assistive Safety Devices Distribution Service (Senior Safety Program)

### Personal Information (Required)

Date of Request: \_\_\_\_\_

Applicant Name (First, Middle Initial, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male  Unknown

What is your gender identity?  Non-Disclosure  Female  Male  Transgender-Female  
 Transgender-Male

Applicant's Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: **ND** Zip: \_\_\_\_\_

Mailing Address, if different (must include): \_\_\_\_\_

County: \_\_\_\_\_ Reservation, if applicable: \_\_\_\_\_

Applicant's Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about this program?  Brochure  Internet Ad  Word of Mouth

Presentation  Medical Professional  ND Assistive Website

ND Assistive Consultant: \_\_\_\_\_ Other: \_\_\_\_\_

ND Assistive now offers occupational therapy home safety evaluations to assist with device selection, setup and training. Would you like more information about this service?  Yes  No

### Demographic Information

What is your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

What is your primary language?

- English
- Other

What is your race?

- American Indian/ Native Alaskan
- Asian
- Black/ African American
- Native Hawaiian/ Other Pacific Islander
- Non-Minority (White, non-Hispanic)
- White-Hispanic
- Other

Do you live alone?

- No
- Yes
- Unknown

Do you feel socially isolated?

- No
- Yes

Are you currently enrolled in Medicare? \_\_\_Yes \_\_\_No

Are you currently enrolled in Medicaid? \_\_\_Yes \_\_\_No

Are you currently enrolled in Northland PACE? \_\_\_Yes \_\_\_No

**Priority Funding Areas (check yes or no)**

*Please note that funding for this program is a limited financial resource through the Older Americans Act.*

*Preference will be given to those who fall within the priority funding areas first.*

- I live in a rural area (**not** Bismarck, Grand Forks, or Fargo). \_\_\_Yes \_\_\_No
- I am at risk of being placed in a skilled nursing facility. \_\_\_Yes \_\_\_No
- My income level is below the national poverty level (see chart below). \_\_\_Yes \_\_\_No

<b>2025 HHS Poverty Guidelines</b> (effective January 11, 2025)	
<b>Size of Family Unit</b>	<b>Poverty Guideline</b>
1	\$15,650
2	\$21,150
3	\$26,650
4	\$32,150
5	\$37,650
6	\$43,150
7	\$48,650
8	\$54,150
<b>For each additional person, add</b>	<b>\$5,500</b>

**Eligible Items:**

- Alerting Devices for Hearing Loss
- Anti-Elopement Devices such as Wandering Alarms (device only)
- Bed Rails (limited options)
- Caregiver Pager System
- Emergency Response Systems (device only)
- Grab Bars (stainless steel only)
- Handheld Shower Heads
- Medication Dispensers and Reminders
- Personal Hearing Amplifiers
- Portable Seat Lift
- Shower Chairs (provide inside measurements of bathtub)
- Adaptive Silverware
- Toilet Safety Frames/Rails (limited options)
- Toilet Seat Risers (limited options)
- Tub Rails (limited options)
- Tub Transfer Benches (provide inside measurements of bathtub)
- Voice Amplifiers and Accessories
- Threshold Ramps

## Devices Requested

Please list the assistive safety devices you are requesting in order of importance. Please only put one device per line. If you live in an Assisted Living residence, please check with the facility to see if devices are allowed before requesting.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

Please list any health concerns or disabilities that contribute to your need for the requested item(s).

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How did you determine what assistive technology was appropriate for your needs? i.e. My OT recommended. I received a device demonstration from an Assistive staff member.

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Explain how this device(s) increases your safety/ independence on a day-to-day basis.

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If you are requesting a **toilet seat riser, shower chair, bathtub transfer bench, grab bar, or bed transfer handle**, please provide the following information: Height: \_\_\_\_\_ Weight: \_\_\_\_\_

If you are requesting a **toilet seat riser**, which shape of toilet do you have?

Standard round  Elongated

If you are requesting a **shower chair**, please complete the following:

Does the shower chair need to have a backrest?  Yes  No

Does the shower chair need to have arms?  Yes  No

What is the inside measurement of the bathtub or shower where the chair will be used? \_\_\_\_\_

If you are requesting a **grab bar(s)**, please provide the length(s) and number of grab bars needed. Standard, ADA-compliant grab bars are available in the following sizes: 12", 16", 18", 24", 30", 32", 36", and 42". The size needed is dependent on the space and the distance between studs (if installed horizontally).

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If you are requesting an **emergency alerting system**, do you have a landline? Yes \_\_\_ No \_\_\_

**Should the devices be shipped to your home?** \_\_\_ Yes \_\_\_ No

**If no, please provide the name and address** to which they should be shipped. Please note that not all vendors are able to ship to PO Boxes. Therefore, the street and mailing address should be provided.

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### **Survey Contact**

After your equipment arrives you will receive a survey asking about your experience with this program and how the equipment is working for you. How do you wish to be contacted for this survey?

\_\_\_ Mail (we will use the address you provided)

\_\_\_ Email (please provide) \_\_\_\_\_

### **Alternate Contact Person (Family, Friend, etc...)**

If you are completing this form on behalf of someone, or if you would prefer we contact someone other than yourself regarding your request, please complete the contact information below.

Contact Name and Relationship/Role: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

### **Professional Contact Person (Social Worker, Hearing Outreach, Vision Outreach, Case Manager, etc...)**

If you are working with a professional and would prefer we contact them regarding your application, please complete the contact information below.

Professional Contact Name and Role: \_\_\_\_\_

Professional Contact Phone Number: \_\_\_\_\_

Professional Contact Email Address: \_\_\_\_\_

## **Submittal Instructions**

**Email** completed form to: [seniorsafety@ndassistive.org](mailto:seniorsafety@ndassistive.org)

Or **mail** completed form to:

ND Assistive/ Senior Safety  
3240 15<sup>th</sup> St. South, Suite B  
Fargo, ND 58104

Or **fax** completed form to: 701-365-6242 Attn.: Senior Safety

## **Questions?**

Please call 800-895-4728 (toll-free), 701-258-4728 (Bismarck local), or 701-365-4728 (Fargo local). You may also email the Senior Safety Program at [seniorsafety@ndassistive.org](mailto:seniorsafety@ndassistive.org)

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