Application for Assistance

Applicant: _____

Driver or SS# _____ Phone: _____

Address: _____

e-Mail: _____

How long at above address? _____ How long at job? _____

Weight Range: _____ Height: _____ Date of Birth: _____

Disability: _____

Co-Applicant: _____

Driver or SS# _____ Phone: _____

Address: _____

e-Mail: _____

How long at above address? _____ How long at job? _____

Relationship to Applicant: _____

Co-applicant and Applicant agree to be jointly responsible for Equip maintenance. Most often the person with disability using the equipment is unable to transport the equipment without assistance.

Equipment:

_____

_____

_____

_____

***Comments**, Disability, Circumstances, Concerns ... For extended use complete back of white original form only, NOT yellow.*

_____

_____

_____

_____

_____

_____

How did you find us? _____ Do you know someone who would enjoy volunteering? _____

Applicants **"hold WheelchairHelp.org inc harmless"** for any liability, accident, or damage related to equipment.

Applicants *(signature)*	Co-Applicants *(signature)*	WheelchairHelp Staff *(signature)*
Applicants *(printed)* date	Co-Applicants *(printed)* date	*(printed)* date

WheelchairHelp.org inc 501c3 574 **295-2230** • 888-670-2221 fax • 515 East St • Elkhart, IN 46516

Wheelchair Help is Community Supported and receives no gevernment, United Way or Medicare…funding.

Fees Subsidize Gifts and Loaners

Donations not expected, but always welcome.

Wheelchair Help's Mission is to Improve Quality of Life and Health by providing wheelchairs and mobility equipment not funded by Medicare, Medicaid or Insurance.

Programs Include:
Gifts • Loaners
Sponsor a Scooter
Budget Assistance • Subsidies
Support Network
Music Outreach • Project Ramp

Safety tips:

- Do not exceed weight limit with patient and baggage.
- Inspect equipment regularly especially brakes (wheel locks) on wheelchairs and rollators.
- Client agrees to report any safety hazards immediately or accept full responsibility.
- Swing legrests away before entering wheelchair and use wheel locks (brakes).
- When descending an incline it is safer for the caregiver to pull the wheelchair down the incline to prevent run-away.
- Client agrees to read owner's manual for safe use of equipment and use as directed.

Part 2: Only required for Gift or Budget Assistance (SS# required of both applicants)

Assistance Requested? _____

Do you have Medicare, Medicaid or Insurance? _____ What portion will Medicare…Insurance pay ***if any***: $ _____

Can you afford to purchase this equipment at regular price from a local supplier, explain? _____

How much can you raise towards Equipment Costs, including family, friends, community…? $ _____

Briefly explain your financial situation: _____

_____

What organizations are most likely to participate? Employees/Employer, Club, Church, School… _____

Please list agencies you have contacted and the probablility of us working with them? _____

Would this equipment be used in the home, travel or both? _____

Is home wheelchair accessible? Width of Halls and Doors? Is home accessiblity assistance needed? _____

_____

How would you transport this equipment in vehicle to activities…? _____

Model and year of vehicle: Van, Truck, Car… _____

Do you drive it? Alone? Who would assist you in travel? _____

How would this equipment effect your lifestyle and health? _____

_____

___ What are your family's concerns on mobility in the home and outside? What hazards do you face, and how would motorized mobility affect safety?

_____

What does your Dr recommend? Dr & Phone:_____

Would Dr write a prescription for equipment assuming Medicare… Insurance is not paying? _____

Occupational or Physical Therapists & Phone, if applicable (is OT assistance required): _____

If applicable, is applicant in a nursing home, how long? _____ Probability of coming home within 1 year? _____

Do you authorize WheelchairHelp.org inc to consult with sponsors and medical professionals or send them copies of this application *or relevant parts*? _____