Foundation for Rehabilitation Equipment & Endowment:
South Hampton Roads, VA

P. O. Box 66207
Virginia Beach,VA
23466

Phone: 757-771-6183
Fax:757-447-6333

Application Cover Sheet

Dear Applicant,

Thank you for your interest in the South Hampton Roads Chapter of the Foundation for Rehabilitation Equipment and Endowment (F.R.E.E.). We hope to assist you in your current time of need. Enclosed is an application and information about our foundation. **Your application can not be processed until it is completely filled out and all requested information is attached.** Please refer to the check off list in this packet to ensure that your application is complete before it is mailed or faxed. We may contact you after receiving your application to gather further information about your needs or proof of income.

The F.R.E.E. Foundation hopes to assist you as far as possible. However, the approval of your request is dependent on several factors. F.R.E.E. may approve your request fully or partially, depending on devices that are available to us. F.R.E.E. recycles gently used items donated by the community. Therefore, the items we have available may vary at any time. As well, requests are dependent upon meeting criteria for assistance. F.R.E.E. is considered a provider of last resort and attempts to provide assistance when no other resources are available.

Please note that, like a Physician's prescription for medicine, a Physician's prescription is also required for medical equipment. It must be sent with the application. If you are requesting a power chair or scooter please have your physician complete a "Letter of Medical Necessity" (a form is provided on http://www.free-foundation.org). This will provide us with more insight to your situation. **F.R.E.E. does not gift respiratory equipment such as nebulizers.**
** **If approved, all items gifted to you are yours, and are your responsibility to maintain.**

Sincerely,

Valeria Mitchell, President, South Hampton Roads Chapter
shr@free-foundation.org

Remember to:

Complete all portions of this application

Sign & date the application by you or an individual assisting you.

Attach the Physician's prescription (Required for **ALL** equipment)

Sign Release of Medical Information/Waiver Form

Attach a **Medical Letter of Necessity** (For power chair and scooters **ONLY**)

Fax, email scanned copy or mail completed application to:
Fax: 757-447-6333
Email: shr@free-foundation.org
Foundation for Rehabilitation Equipment & Endowment-SHR Chapter
P.O. Box 66207
Virginia Beach, VA 23466

Application will be held until all items are received

Application

OFFICE USE ONLY
DATE APPLICATION RECEIVED _____ ALL INFORMATION RECEIVED _____
APPROVED DATE _____
DENIED DUE TO DELIVERY DATE _____

Applicant's name _____ DOB _____

Telephone ( ) _____

Address _____City of_____County of_____

Advocate helping with application: _____ Phone ( ) _____ Fax ( ) _____

E-mail address _____

Demographics (For reporting only. This information does not affect the outcome of your request.)

Age: _____ **Gender:** ☐ **M** ☐ **F** **Height:** _____ **Weight:** _____

Employment status: ☐ Retired ☐ Employed ☐ Unemployed

Race: ☐ African-Amer ☐ Asian-Amer ☐ Hispanic-Amer ☐ Caucasian ☐ Other_____

Will the device requested help with any of the following? (Check all the apply)

☐ Home ☐ School ☐ Work ☐ Community activities

1. What are your current medical problems and when did they start? _____

_____

2. Your Doctor's name: _____ Doctor's Phone # _____

3. What equipment is being requested? _____
(A doctor's prescription must be attached before your request can be reviewed. All requests for power wheelchairs, scooters, and items over $500.00 must include a Letter of Medical Necessity. On the website, you will find a form that can be used.)

4. What assistive device(s) do you currently use? _____

5. Can any other source help with the purchase of the item? ☐ Family ☐ Church ☐ Other

6. What are your current Monthly uncovered Medical expenses (out of pocket)? $ _____

7. Current financial status: Applicant's HOUSEHOLD MONTHLY income $_____

Number of Dependents living in household (including applicant) _____

8. Please check if you currently have:
☐ Health Insurance ☐ Medicare ☐ Medicaid ☐ **I DO NOT have any insurance**

Please provide: Policy name _____ Policy number _____

The undersigned certifies that all information provided within this application is accurate to the best of your knowledge and is subject to verification.

Signature: X **Date:**

Authorization to Release Medical and Financial Information/Waiver Agreement

Client Name _____
(Please print)

Client Telephone _____

Equipment being requested _____.

I, _____ , the applicant, understand that by completing this form, I am not guaranteed approval of this application. However, my application will be reviewed upon receipt of all necessary information. I realize that if my request is approved that it is a gift to me by the foundation and that this gift may be a used recycled device. If my request is approved, I understand and accept all responsibilities for the equipment. I voluntarily give up any right to sue or hold the Foundation for Rehabilitation Equipment & Endowment, F.R.E.E. Foundation, their members, officers, directors and any of their representatives responsible for any injury incurred by me in the use of this equipment. In return for getting this equipment for free and at no cost, I give up any claim I may have against the above listed individuals and organizations. As well, I assume the responsibility of the maintenance and up keep for the item(s).

I, the undersigned, hereby authorize a representative of the Foundation for Rehabilitation Equipment and Endowment (F.R.E.E.) to review my medical records and to obtain additional information from any treating professional and/or facility involved in my care for the purpose of completing and evaluating my application for equipment assistance. I also authorize a F.R.E.E. representative to obtain information about my income and financial status so that F.R.E.E. can determine and verify that I qualify for assistance under its guidelines.

X_____ _____
Signature of Applicant or Caregiver **Date**

DELIVERY ACKNOWLEDGEMENT

DELIVERY DATE:_____

I, the customer acknowledge receipt of the equipment listed above and the information given to me regarding the equipment. I realize this is a gift to me by the foundation and I understand and accept all responsibilities for the equipment. I waiver any right to hold the Foundation for Rehabilitation Equipment & Endowment and any of it representatives responsible for any injury obtained by the use of this equipment. As well, I assume the responsibility of the maintenance and up keep for the item(s).

Applicant Signature Date

F.R.E.E. Representative signature (Care Coordinator) Date

Virginia Reuse Network Data Collection Tool

This survey is for persons who have received assistive technology (AT) device(s) from our device reuse network and must be filled out by the Customer or a Designee. Use back for comments.

Customer Name: _____ Phone: _____

Where did you get the AT device: SHR Hospital
AT device(s) received: _____

Date equipment received/service delivery was completed: _____

Date this form was received/returned by Customer: _____

☐ Are you (or the person you represent) currently a Client of the Department of Rehabilitative Services (DRS)? If so, who is your counselor: _____

☐ Do you (or the person you represent) have a traumatic spinal cord injury?

☐ Do you (or the person you represent) have a traumatic brain injury?

☐ Are you (or the person you represent) a Veteran?

The primary purpose for which I need (or the person I represent needs) an AT device or service is related to: (CHECK ONE)

- ☐ Education
- ☐ Community Living
- ☐ Employment

Why did you chose to obtain an AT device/service from our program? (CHECK ONE)

- ☐ I could only afford the AT though this program. (I could not afford it through other programs.)
- ☐ The AT was only available to me through this program. (I am not eligible or don't qualify for other programs, the AT is not covered by other funding sources or the specific device I needed is not provided by other programs.)
- ☐ The AT was available to me through other programs, but the system was too complex or the wait time was too long.
- ☐ None of the above

Which of the following best reflects your level of Satisfaction with the services you received? (CHECK ONE)

- ☐ Highly satisfied
- ☐ Satisfied
- ☐ Satisfied somewhat
- ☐ Not at all satisfied

Completed by: _____ Date: _____

Letter of Medical Necessity

DATE: _____
To be completed by Physician for _____
Name of applicant

Address_____ phone # _____

Dear Prescribing Physician,
The Foundation for Rehabilitation Equipment and Endowment requests that this Letter of Medical Necessity be completed as soon as possible on behalf of the individual, which you are writing it for. Their application can NOT be processed until our office receives this "Letter of Medical Necessity".

Medical Diagnosis of Patient:
_____
_____
Equipment requested:
_____

Do you approve of the request?_ _____YES _____ NO (CHECK ONE)

Why or why not? _____
_____
_____
_____

If you approve of this request, Please give a detailed explanation for need of this equipment (how will it increase the patient's independence or improve their functional abilities/quality of life): ___
_____
_____
_____
_____

Signature of Physician:_____ Phone # _____

Print name: _____

Please attach a prescription if you approve of the request.
Thank you for your professional guidance and assistance.

Chapter Fax Numbers:
Roanoke 540-777-1030
Lynchburg Fax number: 434-846-3773
Northern Shenandoah Valley 303-593-3519
South Hampton Roads 757-447-6333
Richmond 804-767-4417