Dear Applicant,

Thank you for your interest in the Foundation for Rehabilitation Equipment and Endowment. 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. We may contact you after receiving your application to gather further information about your needs or proof of income.

The FREE Foundation hopes to assist you as far as possible. However, the approval of your request is dependent on several factors. FREE may approve your request fully or partially, depending on devices that are available to us. FREE 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. FREE is considered a provider of last resort and attempts to provide assistance when no other resources are available.

Please note that a Physician's prescription 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 in this application). This will provide us with more insight to your situation.

** **If approved, all items gifted to you are yours and are your responsibility to maintain.**

Sincerely,

Tracy Meador, Executive Assistant
Foundation for Rehabilitation
Equipment and Endowment
Phone (540) 777-4929
Fax (540) 777-1030

February 2007
Original May 1, 2002

OFFICE USE ONLY

DATE APPLICATION RECEIVED _______
ALL INFORMATION RECEIVED _______
- ❑ APPROVED DATE _______
- DELIVERY DATE _______
- ❑ DENIED DUE TO

Application for Assistance

Applicant's name ______________________SSN _________________DOB__________
Address ____
City of___________________________ or County of _____________________________
State, Zip code_________ ______Telephone (___)__________ ____________________
Advocate helping with application: ____
Telephone (____)______________________FAX (___)_____________________________

Age:_______ Gender: M____F____ Height:_________ Weight:_________

Employment status: Retired______ Employed_______ Unemployed:________

Race: African-American _______ Asian-American _______ Other _______
Hispanic-American _______ White _______
Will the device requested help with any of the following (check all that apply)
_______school __________Work _______Community activities

1. What are your current medical problems and when did they start?____________________
   ____
   Your Doctor's Name:___________________________ Doctor's Number_______________

2. What equipment is being requested? ____
   A doctor's prescription must be attached before your request can be reviewed.

3. **For all requests over $500 a Medical Letter of Necessity must be attached. Enclosed you will find a form that can be used.**

4. What assistive devices do you currently use? ____________________________________

5. Can any other source (you,family,church) help with the purchase of the item? __________

6. What is your current Monthly uncovered Medical expense (out of pocket)? $__________

7. Current financial status:
   Applicant's HOUSEHOLD MONTHLY income (taxable & non-taxable) $__________
   Total value of Assets (real estate and property values) $__________
   Number of Dependents living in **household** (*including applicant)* __________

8. Please circle any that you currently have: **Health Insurance** **Medicare** **Medicaid**
   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: *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___(CIRCLE 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.
Please return this form to: **FREE**
P.O. Box 8873
Roanoke, VA 24014
Fax (540) 777-1030

Updated Feb., 2007
Original July 2001

Print Your Name____________________

Telephone (_____)___________________

Authorization to Release
Medical and Financial Information

I, the undersigned, hereby authorize a representative of the Foundation for Rehabilitation Equipment and Endowment (FREE) 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 FREE representative to obtain information about my income and financial status so that FREE can determine and verify that I qualify for assistance under its guidelines.

____

Signature of Applicant or Caregiver   Date

WAIVER AGREEMENT

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 gently used recycled device. If my request is approved, 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).

____

Signature of Applicant or Caregiver   Date

FREE Fax # 540-777-1030

Updated Feb., 2007
Original May 2001

Application cover sheet

Remember to:

- **Complete all** portions of this application
- **Sign & date the Application** by you or an individual assisting you.
- **Attach** the Physician's prescription
- **Attach** a **Medical Letter of Necessity** (power chair/scooter) (Sample form attached or physician may submit his/her own.)
- **Sign Release of Medical Information and Waiver Form**
- **Forward** completed application to: **P. O. Box 8873, Roanoke, VA 24014**
- **Fax** to 540-777-1030

_____________________________ _____________________________

Signature of person assisting you **Date**

Ex.) Case worker, therapist, social worker etc.

***Application will be returned unless all items are received**

Updated Feb., 2007
Original November 2002