



Foundation for Rehabilitation Equipment & Endowment:
Roanoke, VA

**P.O. Box 8873
Roanoke, VA 24014**

**Phone: 540-777-4929
Fax: 540-777-1030**

Application Cover Sheet

Dear Applicant,

Thank you for your interest in the Roanoke 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,

Tracy Meador,
Manager of Operations
tracy@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

- Sign Release of Medical Information/Waiver Form**

- Attach a Medical Letter of Necessity** (Only required for power wheelchair, scooter, items over \$500.00; Physician may either use sample form on website or submit his/her own)

- Fax, email scanned copy, or mail completed application to:**
Fax: 540-777-1030
Email: tracy@free-foundation.org
Foundation for Rehabilitation Equipment & Endowment-Roanoke Chapter
P. O. Box 8873
Roanoke, VA 24014

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 UnemployedRace: African-Amer Asian-Amer Hispanic-Amer Caucasian Other _____

Will the device requested help with any of the following? (Check all that 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 (taxable & non-taxable) \$ _____

Total value of Assets (real estate and property values) \$ _____

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