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,

Crystal Ross, Program Assistant
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 **Date Received**_____

If you are able to make a charitable donation so we can continue our services, please include with your application.

***$1.00** ***$5.00** ***$10.00** ***not able to give at this time**

Applicant's name _____ Telephone ( )_____

Address _____City of_____County of_____

State_____Advocate/company: _____ Phone ( ) _____DOB_____

Demographics:

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 for ALL equipment. Requests for power chairs and scooters 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? (Such as church or family) YES or NO

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

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

8. Number of Dependents living in household (including applicant) $_____

9. Please circle if you currently have:

Health Insurance Medicare Medicaid No Insurance

10. In the last 30 days:

How many times have you fallen? #_____

How many times have you been to the emergency Room? #_____

How many times have you been to the hospital? #_____

11. Without this equipment will you have to change your home residence by moving to any of the following?

In with a family member Assisted living Nursing home (circle all that apply)

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**

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.

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
Williamsburg 757-337-5032