



Northern Shenandoah Valley FREE Foundation
PO Box 237
Winchester, VA 22604-0237
540-664-7552

Dear Applicant,

Thank you for your interest in the Northern Shenandoah Valley Foundation for Rehabilitation Equipment and Endowment (FREE). 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,

Stephanie Mahan, PT, ATP
President
Northern Shenandoah Valley FREE Foundation
smahan@free-foundation.org

Letter of Medical Necessity (Only required for items over \$500.00 or wheelchairs)

DATE: _____

To be completed by Physician for _____
Name of applicant

Applicant's Address _____
Applicants 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 applicant named above. The applicant's request **CANNOT** be processed until our office receives this.

LETTER OF MEDICAL NECESSITY

Medical Diagnosis of Patient (Please list primary Dx and all co morbidities)

Equipment requested: _____

Do you approve of the request? YES NO
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): _____

***Please attach a prescription if you approve of the request.**

Signature of Physician: _____

Physician's name printed _____

Physician Phone # _____

Thank you for your professional guidance and assistance.

Please return this form to:
Northern Shenandoah Valley FREE Foundation
P.O. Box 237
Winchester VA, 22604-0237

Client Name _____

(Please print)

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

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**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 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, the Northern Shenandoah FREE 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).

\_\_\_\_\_

Signature of Applicant or Caregiver

Date



## 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**  
(For power wheelchair, scooter, items over \$500.00)  
Physician may either use sample form attached or submit his/her own.
- **Sign Release of Medical Information and Waiver Form**
- **Forward completed application to:**  
Northern Shenandoah Valley FREE Foundation  
P. O. Box 237  
Winchester, VA 22604

### **Is someone assisting you with this application?**

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

**Name** \_\_\_\_\_

**Phone #** \_\_\_\_\_

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

**OFFICE USE ONLY**

DATE APPLICATION RECEIVED \_\_\_\_\_ ALL INFORMATION RECEIVED \_\_\_\_\_  
 APPROVED DATE \_\_\_\_\_ DELIVERY DATE \_\_\_\_\_  
 DENIED DUE TO \_\_\_\_\_

Applicant's name \_\_\_\_\_ DOB \_\_\_\_\_  
 SSN \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
 Address \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Advocate helping with application: \_\_\_\_\_  
 Telephone ( ) \_\_\_\_\_ FAX ( ) \_\_\_\_\_

**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-American  Asian-American  Hispanic-American  White  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.
4. For all requests over \$500 a Letter of Medical Necessity must be attached. Enclosed you will find a form that can be used.
5. What assistive devices do you currently use? \_\_\_\_\_
6. Can any other source help with the purchase of the item? Family  Church  Other
7. What is your current Monthly uncovered Medical expense (out of pocket)? \$ \_\_\_\_\_
8. 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) \_\_\_\_\_
9. Please check if 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:** \_\_\_\_\_



Northern Shenandoah Valley Chapter

DELIVERY FORM

Client Information

Customer Name \_\_\_\_\_

Order Date: \_\_\_\_\_ Delivery Date: \_\_\_\_\_

Physician Information

Physician's name \_\_\_\_\_

Prescription on hand: YES

| Gift Description | Inventory # | Quantity |
|------------------|-------------|----------|
|                  |             |          |
|                  |             |          |

Client Education Information

Instructed in use of equipment provided YES

Instructed in care/maintenance YES

Instruction provided by

FREE representative \_\_\_\_\_

or \_\_\_\_\_ Name

Clients treating clinician \_\_\_\_\_

Name

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 give up any right to sue or hold the Foundation for Rehabilitation Equipment & Endowment, the Northern Shenandoah FREE Foundation, their members, officers, directors and any of it representatives responsible for any injury incurred by me in the use of this equipment. As well, I assume the responsibility of the maintenance and up keep for the item (s).

\_\_\_\_\_

Customer Signature

date

\_\_\_\_\_

FREE Representative signature

date



Northern Shenandoah Valley Chapter

FREE FOUNDATION SURVEY

Name: \_\_\_\_\_

Equipment Gifted: \_\_\_\_\_

Phone number: \_\_\_\_\_

E-mail \_\_\_\_\_

How is the equipment working for you? \_\_\_\_\_

Do you feel this equipment has increased your independence when used? YES or NO

What can you do with this Equipment that would not have been possible without it? \_\_\_\_\_

What tasks are you able to participate in? \_\_\_\_\_

Were you able to care for yourself before receiving this equipment? (Circle one)

NOT AT ALL SOMEWHAT MOSTLY INDEPENDENT

Are you able to care for yourself with the use of this equipment now? (Circle one)

NOT AT ALL SOMEWHAT MOSTLY INDEPENDENT

Were you mobile (able to walk) before receiving this equipment? (Circle one)

NOT AT ALL SOMEWHAT MOSTLY INDEPENDENT

Are you mobile (able to walk) with the use of this equipment? (Circle one)

NOT AT ALL SOMEWHAT MOSTLY INDEPENDENT

How long have you lived at your current residence? \_\_\_\_\_

Without this equipment would you have had to move to one of the following? YES or NO

If yes, circle which one? NURSING FACILITY ASSISTED LIVING WITH A FAMILY MEMBER

How many falls a week did you have before receiving the equipment? (x4) \_\_\_\_\_

How many falls a week are you having since you received this equipment? (x4) \_\_\_\_\_

How many Emergency room visits per month did you have before receiving this equipment? \_\_\_\_\_

How many Emergency room visits have you had per month since you received this equipment? \_\_\_\_\_

How many Hospital stays per month did you have before receiving this equipment? \_\_\_\_\_

How many Hospital stays have you had per month since you received this equipment? \_\_\_\_\_

Date of last employment \_\_\_\_\_. Are you interested in career counseling? YES or NO

Would you be willing to donate your equipment back to FREE when not needed? YES or NO

Additional comments: \_\_\_\_\_