Wheels of Freedom Project:

Founding Sponsor:

AAMCO Transmissions Total Car Care

Prescott Valley

Wheels of Freedom Project
6871 E. First St.
Prescott Valley, AZ 86314
Phone: 928-759-5588
Fax: 928-759-0127
www.wheelsoffreedomproject.org

Application Cover Sheet

Dear Applicant,

Thank you for your interest in The Wheels of Freedom Project (W.O.F.). We hope to assist you in your current time of need. Enclosed is an application and information about our project. **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.

W.O.F. hopes to assist you as far as possible. However, the approval of your request is dependent on several factors. W.O.F. may approve your request fully or partially, depending on devices that are available to us. W.O.F. refurbishes used powered wheelchairs and scooters 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. W.O.F. 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 in the application documents. 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,

Gary Denton,
Manager of Operations
gdenton@wheelsoffreedomproject.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)

☐ **Attach** Veterans Affairs I.D. (Copy) and a DD-214 Form. You may redact Social Security # on form.

☐ **Sign Release of Medical Information/Waiver Form**

☐ **Attach** a **Medical Letter of Necessity** (For power bair/electric scooters **ONLY**)

☐ **Fax, email scanned copy, or mail completed application to:** Fax: 928-759-0127.
Email: gdenton@wheelsoffreedomproject.org

Wheels of Freedom Project
6871 E. First St.
Prescott Valley, AZ 86314
Phone: 928-759-5588 - Available 24/7
Email: gdenton@wheelsoffreedomproject.org
Website: www.wheelsoffreedomproject.org

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_____State/Zip_____

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

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.

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. Once approved, all personal information will be destroyed.

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 project and that this gift may be a used refurbished 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 Wheels of Freedom Project (W.O.F.), 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 Wheels of Freedom Project (W.O.F.) 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 W.O.F. representative to obtain information about my income and financial status so that W.O.F. 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 Wheels of Freedom Project (W.O.F.) 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.

W.O.F.
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Email: gdenton@wheelsoffreedomproject.org