Wheelchairs 4 Kids

APPLICATION

Please read the following carefully before signing.

- The child must be 21 years of age or younger.
- The application must be filled out entirely. Incomplete applications will not be accepted.
- The application, medical authorization, and liability/publicity release must include original signatures. Copies or stamps will not be accepted.
- Altering the wording on the medical or liability/publicity release form is strictly prohibited.
- A current photograph of the child must be included. Please include photos (i.e. an ill-fitting wheelchair, home without a ramp, etc.) and supporting documentation depicting the need for requested equipment/modification.
- Include copies of denials from Medicaid or insurance.
- You may not be working with another organization for the same request.
- Wheelchairs 4 Kids may contact local and national organizations and businesses to assist with your request. By signing below, you are granting permission to Wheelchairs 4 Kids to share the medical and personal information included in this application with potential sponsors and/or vendors.
- Wheelchairs 4 Kids may use your child's story and likeness on their website, in press releases, and for general publicity unless you request and complete an "opt out" form upon submission of this application.
- Wheelchairs 4 Kids makes the final determination with regard to what equipment may be provided. Upon delivery, the equipment/modification becomes the sole responsibility of the parents/guardian(s). Wheelchairs 4 Kids is not responsible for maintenance, repairs, or replacement parts including batteries.
- You may not contact sponsors or vendors without Wheelchairs 4 Kids written consent.

Please send the completed application with supporting pictures and documentation to:

Wheelchairs 4 Kids
1406 Stonehaven Way
Tarpon Springs, FL 34689

I have read and agree to the terms listed above.

Yaniya Idall
(Parent or legal guardian's signature)

10-10-12
Date

Wheelchairs 4 Kids

APPLICATION

Child's name: Christopher Hall ☒Boy ☐ Girl Age: 18 Date of Birth: 8-22-94

Address: 5206 White Egret LN

City: Lakeland State: FL Zip: 33811

County: Polk

Parent(s)/Guardian Email: poisontanya@hotmail.com

Phone: (863) 510-6268 Cell: (757) 323-2954

Mother's Name: Tanya Hall Father's Name: DAVID HALL
(Please use legal names as listed on government issued ID, i.e. Driver's license)

Legal Guardian: DAVID + TANYA Hall
(Legal Guardians must attach legal proof of guardianship)

Please list all persons living in the permanent residence of the child:

Full name	Relationship to child	Age
Tiffany Hall	Sister	17
Aaron Hall	brother	14

How did you hear about Wheelchairs 4 Kids? pt @ Jean a Dell

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Child's diagnosis: GM1

Date of diagnosis: Aug 2007

Primary Physician: Dean, Joan Phone: 863-401-2807

Fax: 863-401-2806 Email: _____

Rehab Doctor: _____ Phone: _____

Orthopedic Doctor: _____ Phone: _____

PT or OT: _____ Phone: _____

Social worker: _____ Phone: _____

Please check the mobility/accessibility equipment or modification you are requesting:

☐ Manual wheelchair ☐ Tilt wheelchair ☐ Power wheelchair ☐ Stander
☐ Gait Trainer/walker ☐ Ramp for home ☐ Hoyer lift ☐ Bathing solutions
☒ Vehicle modification ☒ Other lift on VAN

Please note that you must either own your home or vehicle to qualify for home or vehicle modifications or provide a notarized letter from the owner authorizing the modification.

Brief explanation of child's current situation and reason for requesting new equipment or modifications:

Chris has a powerchair that he uses daily. The lift on the Van will not go all the way up to let in on. We have to use a diff chair to transport him. If I have to pick him up from School, it will be impossible cause the chair wont be able to come. We would have to carry him.

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Current Equipment Provider: BRAUN UVL UNDERVAN chair lift

Model and year of current equipment: 2003 Ford Econoline E250 Handicap Van

Do you own your home? X Do you own your vehicle? X

Does your child have Medicaid coverage? X Medicaid #: 8900924397

Insurance Carrier: Humana Military Phone: 1-800-444.5445

Address: PO Box 740615

City: Louisville State: KY Zip: 40201

Contact Person: Linda Donovan

Is there any other form of coverage? X

If yes, other coverage provider: Phone:

Other coverage provider: Phone:

Mother's Employer: N/A Phone:

Supervisor:

Father's Employer: Joy Global Phone: 863-804-013(

Supervisor: Carl Combs

Legal Guardian's Employer: Same as above Phone: Same as Above

Supervisor: Same as above

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Liability/Publicity Release

Please initial each section and sign below

Section I **Initial:** TH

By my signature below I, as parent or legal guardian of Christopher Hall (herein after referred to as recipient) assume all risk of property damage, harm or injury to any individual which may occur as a result of participating in Wheelchairs 4 Kids programs. I hereby release and forever discharge Wheelchairs 4 Kids, Inc., its agents, officers, directors, employees, volunteers, vendors, sponsors or any other persons, firms or corporations from any liability, costs and damages resulting from use of any equipment or modifications provided by Wheelchairs 4 Kids or participation in Wheelchairs 4 Kids programs or events.

Section II **Initial:** TH

As parents or legal guardians, I/We give *Wheelchairs 4 Kids, Inc.* permission to obtain medical information which may be necessary to determine eligibility or which equipment may be most suitable for the child's particular situation.

Section III **Initial:** TH

I/we understand that *Wheelchairs 4 Kids, Inc.* may seek sponsorship and/or volunteers from local and national businesses and organizations. We accept that it may be necessary to share the recipient's basic information and likeness. Wheelchairs 4 Kids will not share last names, addresses or phone numbers with anyone without the permission of the recipient's parents or legal guardians.

Section III **Initial:** TH

I/We agree that *Wheelchairs 4 Kids, Inc.* may use the name, likeness, image, voice, biographical information and/or appearance of recipient as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, applications, and the like, taken or made on behalf of *Wheelchairs 4 Kids, Inc.* programs or activities. I agree that *Wheelchairs 4 Kids, Inc.* has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the *Wheelchairs 4 Kids* mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release *Wheelchairs 4 Kids* and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

Tanya Hall	Tanya Hall	10-10-12
Name of Parent or Guardian	Signature of Parent or Guardian	Date
MARY MEEHAN	ARNP Mary Meehan ARNP	
Name of Witness	Signature of Witness	Date

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Medical Needs Evaluation

(To be completed by doctor or licensed therapist)

Patient's name: Christopher Hall Birthdate: 8/22/1994

Diagnosis: GTAngliosidosis - Juvenile

Patient has been in your care since: Nov. 2012

The following information is requested in order to provide the best DME for the patient. Please complete to the best of your knowledge.

Please provide measurements:

Patient's overall height: _____ Patient's weight: _____

Width of hips (from outside to outside): _____

Trunk height (top of shoulder to bottom of rear-end while seated): _____

Lower leg length (From bottom of thigh to bottom of heel): _____

Seat depth (From back of rear end to behind the knee): _____

Can child sit up independently? ☑ Yes ☐ No ☐ with difficulty

Can the child hold their head up independently? ☑ Yes ☐ No ☐ with difficulty

Can child propel a manual wheelchair? ☑ Yes ☐ No ☐ with difficulty

Can child operate a power joystick? ☑ Yes ☐ No Method (left hand, right hand, other): right hand

Does the child need assistance with transfers? ☑ Yes ☐ No

Does the child have a caregiver? ☑ Yes ☐ No

Where will the equipment be used? Please check all that apply:

☑ In a home or apartment ☑ At school ☑ City streets ☑ Rural areas ☐ Snow

Will the equipment need to be transported? ☑ Yes ☐ No

If so, what type of vehicle will be used? Van - Conversion E 250

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Medical Needs Evaluation (Cont'd.)

(To be completed by doctor or licensed therapist)

Are there steps to enter the child's home? ☑ Yes ☐ No If yes, is there a ramp? ☐ Yes ☑ No

Please list the width of the following doors:

Main entrance to the home: _____ Garage entrance: _____

Bedroom: _____ Bathroom: _____

Does the child currently use any DME or assistive device(s)?

Type: Power Chair Brand/Model: Permobil C300 Received date: 2009

Type: _____ Brand/Model: _____ Received date: _____

Type: _____ Brand/Model: _____ Received date: _____

Please list any other issues that may be helpful when choosing the right DME for the child:

Please include copies of DME prescriptions with brief explanation:

Melissa Cooper
Doctor or therapist name

Melissa Cooper
Signature

11/6/2012
Date

Trinity Medical Center
Address 1064 N Broadway Ave.
Bartow, FL 33830
(863) 519-9797

Phone

Fax

City, State, Zip

Email

Mary Meehan ARNP
Witness name

Mary Meehan ARNP
Signature

Date

863-519-9797
Phone