



# **Darrell Gwynn Foundation Wheelchair Donation Program Application**

The Darrell Gwynn Foundation, Inc. (“DGF” or “Foundation”), formed in 2002, exists to prevent, provide for and ultimately cure spinal cord injuries and other debilitating illnesses. To expedite specific cures, the Foundation assists in the funding of targeted research relating to spinal cord injuries. The Foundation is also dedicated to injury prevention, with special emphasis on programs benefitting children. One of the Foundation’s primary objectives is to help improve the quality of life for those already afflicted with injury or illness, by providing necessary equipment or special services.

DGF’s Wheelchair Donation Program exists to provide underprivileged individuals with wheelchairs that they would otherwise be unable to obtain. The Foundation’s goal is to donate a wheelchair that is representative of the applicant’s need and within the fiscal abilities of the Foundation.

DGF is not liable or responsible for any repairs or maintenance to the wheelchair following the donation of the chair to the recipient.

By accepting the wheelchair from DGF, the applicant acknowledges and agrees to the terms of the program and unconditionally releases DGF, its officers, directors, affiliates and agents from any liability following the receipt the chair.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Applicant Information:**

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

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

**Name of person completing the application if other than the patient:** \_\_\_\_\_

**Relationship to applicant:** \_\_\_\_\_

**Employment Information (Applicant)**

Complete this section only if the applicant is employed

Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Employed Since: \_\_\_\_\_

Is the patient a dependent of another individual, as defined by IRS tax reporting purposes on the IRS Form 1040? Yes \_\_\_\_\_ No \_\_\_\_\_

**Parent/Guardian Information**

Complete the following section only if the applicant is a dependent of a parent or guardian applying on behalf of individual.

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

Relationship to Applicant: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Employed Since: \_\_\_\_\_

**Second Parent/Guardian Information**

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

Relationship to Applicant: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Employed Since: \_\_\_\_\_



**Medical Provider Information**

Physician: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

License Number: \_\_\_\_\_

Length of time physician has treated patient: \_\_\_\_\_

**Physical Therapist Information**

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

Telephone: \_\_\_\_\_

State License Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Length of time therapist has treated patient: \_\_\_\_\_

**Financial Information**

Annual Household gross income last calendar year: \$ \_\_\_\_\_ Year: \_\_\_\_\_

Has your annual family income changed significantly this year? If yes, please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of dependent children in family: \_\_\_\_\_

Annual out-of-pocket medical expenses (expenses you incurred that were not covered by insurance) last calendar year.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Authorization for Banking and Financial Records**

Davie, FL

Date:

Re: Determination of Eligibility of Financial Assistance from Darrell Gwynn Foundation

To Whom It May Concern:

This authorizes all banking, financial institutions, credit bureaus, creditors and any other individuals and/or entities in possession of any financial information related to me to furnish full and complete records to The Darrell Gwynn Foundation, 4850 SW 52<sup>nd</sup> Street, Davie, FL 33314 (Tel: 954-792-7223).

This further authorizes the examination of all banking and financial records that will aid representatives of the Foundation to determine whether I am eligible for assistance from the Foundation.

You are directed to disclose financial information to no other party.

\_\_\_\_\_ (SEAL)  
(Print name with social security number)

**Patient Authorization for the Release on Protected Health Information (PHI)**  
**(HIPAA Compliant)**

I, \_\_\_\_\_, hereby authorize The Darrell Gwynn Foundation, its agents, employees, and associates, to release and obtain my protected health information (PHI). This medical authorization hereby authorizes physicians, hospitals and any medical attendant or records custodian to furnish full and complete medical records, applications and information to The Darrell Gwynn Foundation, 4850 SW 52<sup>nd</sup> Ave., Davie, FL 33314 or to any representatives from said Foundation. Should you have questions with this request, please call us and reference our client's name or date of accident.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized receipt and may no longer be protected by state and federal law.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire six (6) months from the signature below. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand I have the right to request access to my protected health information that may be used or disclosed to individuals that are not subject to HIPAA regulations. I understand that once PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, and insurance companies and even may become public record if filed with a court of law.

I understand that refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a healthcare entity or any of its business associates.

This authorization for the protected health information also includes examination reports, hospital records, x-ray/CT-scan films, questionnaires, applications, and the furnishing of any other information including opinions.

I have authorized The Darrell Gwynn Foundation to collect my medical records in connections with \_\_\_\_\_.

Your full cooperation with The Darrell Gwynn Foundation is hereby requested. Please do not disclose any medical information to any insurance adjuster or any other person without written authority from myself.

\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Signature** **Date**

\_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Print Name**

SWORN TO AND SUBSCRIBED before me this \_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_,  
By, \_\_\_\_\_, who is personally known to me or has produced  
\_\_\_\_\_ as identification.

My Commission Expires:

NOTARY PUBLIC

**Documentation Needed**

**Please submit a copy of the following information with your application:**

1. Latest IRS 1040 Form and W-2 Form
2. Latest paycheck stub for applicant or parent(s)/guardian(s)
3. Medicaid denial (if applicable)
4. Insurance denial (if applicable)
5. A letter from the treating physician (must include diagnosis and condition). This letter must have been written in the last year.
6. A prescription from the treating physician stating the type of equipment needed
7. Evaluation by licensed physical therapist (see Appendix A). Evaluation must include type of chair recommended.
8. Copy of Photo ID (for applicant or parent/guardian on behalf of applicant)
9. Copy of birth certificate (for applicant minors only)
10. Applicant photo (photo ID is sufficient if applicant is over the age of 18)

**Declarations**

I verify that the information provided in this application is complete and accurate. I further understand that reported financial information may be verified by an audit as deemed necessary by The Darrell Gwynn Foundation. I understand that assistance will terminate if the Foundation becomes aware of any documented case of fraud or of services no longer being prescribed for me or the patient on whose behalf this application was completed. I understand the Foundation reserves the right at any time and without notice to (1) modify the application form; (2) modify or discontinue any or all of the programs and related eligibility criteria; or (3) terminate my assistance at any time.

I authorize the Darrell Gwynn Foundation to obtain information on the patient's information from the prescribing physician, insurance coverage information from my employer or insurance company and other information related to the treatment of spinal cord injuries as necessary to complete the application process or verify the accuracy if any information provided in this application. The Darrell Gwynn Foundation retains the right to periodically monitor or assess the recipient's continued compliance with the goals of the Foundation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Fax and mail original application and documentation to:

The Darrell Gwynn Foundation  
4850 SW 52<sup>nd</sup> St..  
Davie, FL 33314  
FAX: 954-581-7223  
PHONE: 954-792-7223 ext. 105



**DARRELL GWYNN FOUNDATION**

**WHEELCHAIR DONATION PROGRAM**

**APPENDIX A**

The intent of this form is to ensure sufficient information to determine the medical necessity for a wheelchair that best suits the needs of the patient.

**This form must be completed by a licensed physical therapist or certified physiatrist. If the applicant is not currently being treated, please contact the Darrell Gwynn Foundation.**

**Date of Evaluation:** \_\_\_\_\_

**Applicant's Name:** \_\_\_\_\_

**Gender: Male Female Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Injury** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Therapist Name/Title:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Applicant Past/Pending Surgeries:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Does the applicant live on 1<sup>st</sup> floor?** \_\_\_\_\_ **If not, is there an elevator in the building?**  
**Explain:** \_\_\_\_\_

\_\_\_\_\_

Is there a ramp to the residence: Yes No If No, Explain: \_\_\_\_\_

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Are doorways, hallways, and bathrooms in the residence adequately accessible for the type of wheelchair being requested: Yes No

Measurement of narrowest door or hall in home: \_\_\_\_\_

Does applicant have a caregiver available 24 hours/day: Yes No

If no, how many hours/day is a caregiver available: \_\_\_\_\_

**Functional Assessment**

Is applicant able to ambulate: Yes No How far: \_\_\_\_\_

Is a gait aide required: Yes No

Able to self-propel: Yes No How far: \_\_\_\_\_

Household access: Yes No Community Access: Yes No

Propel using both arms: Yes No One arm: Yes No

Able to transfer independently: Yes No If no, type of transfer: \_\_\_\_\_

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Able to stand independently: Yes No Able to perform basic ADLs: Yes No

Able to perform decompression maneuvers (push-ups or forward weigh-shifts):

Yes No

Cognitive Status: (check one) Normal  
Impaired but can operate a wheelchair (power or manual) independently.  
Impaired, dependent on attendant for mobility

Vision: (check one) Normal Impaired but independently mobile in wheelchair  
Impaired, dependent on attendant for mobility

How many total hours a day does the applicant spend in the wheelchair at:  
School \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

Present WC frame type & brand: \_\_\_\_\_ Age of frame: \_\_\_\_\_  
Serial Number: \_\_\_\_\_

Funding Source of present WC: \_\_\_\_\_

**Present WC seating type/brand:** \_\_\_\_\_ **Age of seating system:** \_\_\_\_\_

**Condition of current wheelchair:** \_\_\_\_\_

**Is current WC able to be repaired/modified to meet applicant's needs:** Yes No

**If no, explain:** \_\_\_\_\_

**Does applicant have wheelchair accessible transportation (including a power chair):** Yes No

**Type of transportation:** \_\_\_\_\_

**Type of wheelchair recommended for the applicant:** \_\_\_\_\_

**Evidence that supports your recommendation:** \_\_\_\_\_

**Any additional pertinent information:** \_\_\_\_\_

\_\_\_\_\_  
**Therapist Signature**

\_\_\_\_\_  
**Date**

The Darrell Gwynn Foundation  
4850 SW 52<sup>nd</sup> St..  
Davie, FL 33314  
FAX: 954-581-7223  
PHONE: 954-792-7223 ext. 105