Foundation for Rehabilitation Equipment & Endowment:

F.R.E.E. of VA

Application Cover Sheet

Dear Applicant,

Thank you for reaching out to us during your time of need. F.R.E.E. recycles gently used rehab equipment donated by the community. Therefore, the items we have available may vary at any given time depending on items donated to us.

A note from a medical professional is **REQUIRED** for **ALL** equipment requested.

Your application can not be processed until it is filled out completely and all requested information is attached.

F.R.E.E. does not gift respiratory equipment such as nebulizers, oxygen, or hospital beds.

** **If approved, all items gifted to you are yours and will be your responsibility to maintain.**

Remember:

Completed Application

A note OR Letter of Medical Necessity from medical professional (***REQUIRED FOR ALL EQUIPMENT)**

***REQUEST WILL NOT BE FILLED UNTIL BOTH APPLICATION AND MEDICAL LETTER HAVE BEEN RECEIVED**

SEND COMPLETED APPLICATION TO F.R.E.E. Fax Numbers and emails:

Roanoke: 540-777-1030
roanoke@free-foundation.org
Lynchburg: 434-846-3773
lynchburg@free-foundation.org
NSV: 303-593-3519
nsv@free-foundation.org
South Hampton Roads: 757-447-6333
shr@free-foundation.org
Richmond: 804-767-4417
richmond@free-foundation.org
Williamsburg: 757-337-5032
williamsburg@free-foundation.org
Harrisonburg: 540-564-5125
harrisonburg@free-foundation.org

Application **DOB_____**

Applicant's name _____ Telephone_____

Address_____City of_____County of_____

State_____Advocate/company _____ Phone ( ) _____

Age: _____ Gender: M F Height: _____ Weight: _____

Employment status: *(Circle any that apply)* Veteran Retired Employed Unemployed Disabled Student

Race: African-Amer Asian-Amer Hispanic-Amer Caucasian Other_____

1. What are your current medical problems and when did they start? _____

_____

2. Your Doctor/Therapist name: _____ Phone # _____
(****A note from a medical professional or Letter of Medical Necessity is REQUIRED for ALL equipment.***)

3. What equipment do you need? _____

4. What equipment do you currently have? _____

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

6. What are your current MONTHLY uncovered medical expenses (out of pocket)? $ _____

7. Number of dependents living IN the house (including applicant) # _____

8. Please circle if you currently have: Health Insurance Medicare Medicaid No Insurance

9. In the last **30 days:**
   How many times have you fallen? #_____
   How many times have you gone to the ER? #_____
   How many times have you been to the hospital? #_____

10. Without this equipment will you have to change your home residence by moving? *(Circle any that apply)*

In with a family member Assisted Living Nursing home

The undersigned certifies that all information provided within this application is accurate to the best of your knowledge and is subject to verification. I, the customer, acknowledge that any equipment or information about the equipment given to me is a gift to me from the foundation. I accept all responsibility for the equipment. I waiver any right to hold the Foundation for Rehabilitation Equipment & Endowment and any of its representatives responsible for any injury obtained using this equipment. Also, I assume the responsibility of the maintenance and upkeep for the item(s) and will use them correctly.

SIGNATURE_____DATE_____
Our services are charity based; would you consider a donation for the continuation of our services?

***$1.00 *$5.00 *$10.00 other amount_____ *not able to give currently**

Letter of Medical Necessity

To be completed by Medical Professional DATE: _____

Name of applicant: _____

Address:_____Phone #_____

Dear Medical Professional,

The Foundation for Rehabilitation Equipment and Endowment requests that this Letter of Medical Necessity form be completed as soon as possible on behalf of the individual for whom you are writing it. Their application can **NOT** be processed until our office receives this "Letter of Medical Necessity".

Medical diagnosis of patient**:** _____

Equipment being requested:

Reason for equipment:

LEGIBLY PRINT REFERRAL INFORMATION BELOW INCLUDING CREDENTIALS

Name & Credentials: Phone #:

Agency:

Signature:

Thank you for your professional guidance and assistance.

F.R.E.E. Program Fax Numbers:

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Northern Shenandoah Valley: 303-593-3519
South Hampton Roads: 757-447-6333
Richmond: 804-767-4417
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