



# **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.

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Applicant’s Name

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Signature of Applicant (or legal guardian if under 18)

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Date

## **Application Process**

To be considered for the Darrell Gwynn Foundation Wheelchair Donation Program all requirements must be met and the application must be completed in its entirety. For an application to be considered complete all required documents must be attached.

**Before beginning the application process** please review all of the requirements and necessary documents below.

### **Requirements:**

In order to be considered for the Wheelchair Donation Program an individual must meet the following list of requirements:

- Suffer or have suffered from an injury or illness that leaves the applicant permanently confined to a wheelchair.
- Applicant must be living with injury or illness for at least 6 months.
- Applicant must be at least 2 years old.
- If under the age of 18 the application must be completed and signed by a parent or legal guardian.
- Able to provide documentation from a licensed physician stating the permanency of the applicant's disability.
- Applicant, parent or legal guardian must demonstrate financial need.
- If applicant is covered under private insurance a letter from insurance company stating the reason(s) for denial must be submitted with application.

### **Required Documentation:**

In order for an application to be considered by the Darrell Gwynn Foundation Wheelchair Donation Program an applicant must provide all required documents with the application at the time of submission. **The following items must be provided:**

- Latest IRS 1040 Form and W-2 Form
- Latest paycheck stub for applicant or parent(s)/guardian(s)
- Medicaid denial (if applicable)
- Insurance denial (if applicable)
- Evaluation by licensed physical therapist. Evaluation must include type of chair recommended.
- Treating physician must complete Appendix B
- Signed Liability Agreement
- Signed Photo Release
- Copy of Photo ID (of applicant or parent/guardian on behalf of applicant)
- Copy of birth certificate (for applicant minors only)
- Applicant photo (photo ID is sufficient if applicant is over the age of 18)

**\*\*\*\*If you are unable to provide any of the required documentation above please use a separate sheet of paper to explain why.**

**Applicant Information:**

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

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

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

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

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

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

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

Applicant's Shirt Size:  X-Small  Small  Medium  Large  XL  XXL

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: \_\_\_\_\_

**Please provide a brief description of your medical diagnosis and why you are applying for assistance:**

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**Provide information to assist us in getting to know you better. You may attach a separate sheet of paper:**

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**Health Insurance Information:**

**All applicants must complete this section. Please complete for all insurance carriers. If you have no insurance, please indicate "NO INSURANCE." Please include on a separate page if necessary, all information on Medicare, Medigap, State Children's or other programs.**

Insurance Carrier Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

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

Subscriber Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Annual Deductible: Individual \$ \_\_\_\_\_ Family \$ \_\_\_\_\_

Annual Out-of-Pocket Limit \$ \_\_\_\_\_

Have you reached your out-of-pocket limit? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has a request for a wheelchair been denied by your insurance company? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, please provide a copy of the denial letter with your application.

If no, please provide a brief description stating the reasons you have not gone through your insurance provider:

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Has this insurer ever denied a claim? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you enrolled in any of the following public programs?

Medicare: \_\_\_\_\_ Yes \_\_\_\_\_ No

Medicaid: \_\_\_\_\_ Yes \_\_\_\_\_ No

Vocational  
Rehabilitation \_\_\_\_\_ Yes \_\_\_\_\_ No

Other: \_\_\_\_\_

**Medical Provider Information**

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

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

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

**Physical Therapist Information**

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

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

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

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

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

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**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.

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(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

**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.**

**Physical Therapist Name:** \_\_\_\_\_

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

**And/Or**

**Physiatrist Name:**

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

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

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

**Patient Information: Please use the section to provide the Darrell Gwynn Foundation with as much information as possible in order to process the application.**

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

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

**Gender:**    Male        Female

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Injury** \_\_\_\_\_

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

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

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

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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:  Power  Manuel

Has the patient demonstrated the ability to operate a power chair independently? Yes No

Please provide 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



**DARRELL GWYNN FOUNDATION**  
**WHEELCHAIR DONATION PROGRAM**  
**APPENDIX B**

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 physician. If the applicant is not currently being treated, please contact the Darrell Gwynn Foundation.**

**Physician Name:** \_\_\_\_\_

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

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

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

**State License Number:** \_\_\_\_\_

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

Please state the applicant's medical diagnosis:

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How long have you been treating the applicant? \_\_\_\_\_

Date of injury? (If applicable) \_\_\_\_\_

**re there any pertinent medical conditions the Foundation should be aware of when considering applicants qualification to receive a wheelchair?**

Is the patient permanently disabled? \_\_\_\_\_ Yes \_\_\_\_\_ No

Recommendation of the type of wheelchair: \_\_\_\_\_ Power \_\_\_\_\_ Manual

Please state your reason for the recommendation above:

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Any additional medical information we should consider when fitting the patient for the appropriate wheelchair?

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\_\_\_\_\_  
**Physician 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

**DARRELL GWYNN FOUNDATION, INC.  
RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK,  
AND INDEMNITY AGREEMENT (“AGREEMENT”)**

Event	Location
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IN CONSIDERATION of being given a wheelchair, vehicle, and/or other equipment by the Darrell Gwynn Foundations, Inc. (hereinafter referred to as “DGF”) at the above referenced event at the location identified above (“Location”), and being allowed to participate in any way in the activities (“Activity or Activities”) that may be offered or occur there, I, for myself, my personal representatives, assigns, heirs, guardians and next of kin:

1. ACKNOWLEDGE, agree, and represent that I understand the nature of the wheelchair, vehicle or equipment I am receiving and the environment at the above referenced Location and the Activities that may occur or be offered to me, and that I am qualified, aware, trained, in good health, and in proper physical condition to use, utilize, and operate the wheelchair, vehicle or equipment given to me and to be at the Location and to participate in such Activities. I further agree and warrant that if at any time I believe the conditions to be unsafe, I will immediately discontinue further participation in the Activities. Furthermore, I understand that I am the sole owner of the wheelchair, vehicle and equipment donated to me and that neither DGF, nor any of the Releasees hereinafter defined are responsible in any way for the use, operation of maintenance of the donated item(s) and the items are being donated without any express or implied warranties, including fitness for a particular purpose.
2. FULLY UNDERSTAND that: (a) WHEELCHAIRS, EQUIPMENT, VEHICLES, THAT MAY BE GIVEN TO ME AND THE ACTIVITIES THAT MAY BE OFFERED OR THAT MAY OCCUR AT THE LOCATION INVOLVE RISKS AND DANGERS OF SERIOUS BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS, AND DEATH (“RISKS”); (b) these Risks and dangers may be caused by me, my own actions, or inactions, the actions or inactions of others participating in the Activity, the condition in which the Activity takes place, or THE NEGLIGENCE OF THE “RELEASEES” NAMED BELOW; (c) there may be OTHER RISKS AND SOCIAL AND ECONOMIC LOSSES either not known to me or not readily foreseeable at this time; and I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES I incur as a result of my presence at the Location or participation in the Activity occurring there.
3. AGREE AND WARRANT that I will examine and inspect each wheelchair, vehicle, item of equipment and which I receive or Activity in which I take part and the area in which I may be present, and that, if I observe any condition which I consider to be unacceptably hazardous or dangerous, I will notify the proper authority in charge at the Location or the Activity and will refuse to remain in the area and to take part in the Activity until the condition has been corrected to my satisfaction.
4. HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE Darrell Gwynn Foundation, Inc. Darrell Gwynn, Lisa Gwynn, Edward Gerald Gwynn, Joan A. Gwynn., any company, corporation, general partnership, limited partnership, limited liability company, limited liability partnership or other legal entity in which the foregoing individuals have an interest ownership, their administrators, heirs, directors, agents, officers, representatives, subsidiaries, affiliates, assigns, volunteers, attorneys, and employees, other participants, organizers, any sponsors, advertisers, and, if applicable, owners and lessors of premises on which the donations or the Activity takes place, and owners of any equipment or motorized vehicles that may be used in the ACTIVITIES (each considered one of the “RELEASEES” herein) FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON MY ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE “RELEASEES” OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATIONS; AND I FURTHER AGREE that if, despite this RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT I, or anyone on my behalf, makes a claim against any of the Releasees, I WILL INDEMNIFY, SAVE, DEFEND AND HOLD HARMLESS EACH OF THE RELEASEES from any litigation expenses, attorney fees, loss, liability, damage, or cost which any may incur as the result of such claim.

I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

**Printed Name and Address of Participant:**

Name:

Street :

City:

State:

Zip:

Phone daytime: ( )

Phone eve: ( )

Date:

**Participant's Signature or mark (only if age 18 or over):**

X

**Witness if mark used:**

Name:

Street :

City:

State:

Zip:

Phone daytime: ( )

Phone eve: ( )

Date:

**Witness Signature in case of mark (only if age 18 or over):**

X

**PARENTAL CONSENT**

AND I, the minor's parent and/or legal guardian, understand the nature of rowing activities and the minor's experience and capabilities and believe the minor to be qualified to participate in such activity. I hereby release, discharge, covenant not to sue, and AGREE TO INDEMNIFY, DEFEND, SAVE AND HOLD HARMLESS each of the Releasees referenced above from all liability, claims, demands, losses, or damages on the minor's account caused or alleged to be caused in whole or part by the negligence of the Releasees or otherwise, including negligent rescue operations, and further agree that if, despite this release, I, the minor, or anyone on the minor's behalf makes a claim against any of the above Releasees, I WILL INDEMNIFY, DEFEND, SAVE, AND HOLD HARMLESS each of the Releasees from any litigation expenses, attorney fees, loss liability, damage, or cost any may incur as the result of any such claim.

**Printed Name of Parent/Guardian:**

Name:

Phone daytime: ( )

Address : City: State:

Zip:

**Parent/Guardian Signature (only if participant is under the age of 18):**

Date:

**MEDIA CONSENT FORM**

By signing this form, I, \_\_\_\_\_, give consent to the Darrell Gwynn Foundation to use any photos, images, press releases, etc. containing my name (or child's) and likeness to be used in the promotion of the Darrell Gwynn Foundation. This includes, but is not limited to press releases, brochures, photographs, website, interviews and film.

The undersigned hereby transfers and grants to the Darrell Gwynn Foundation the exclusive right to use and authorize others to use all or any part of my interview/photograph/video or my likeness, regardless of the medium by which it is recorded.

\_\_\_\_\_  
Guardian Printed Name

\_\_\_\_\_  
Minors Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date