**ROTARY CLUB OF PORTLAND**

**PORTLAND ROTARY CHARITABLE TRUST**

**Wheels of Power Application**

Dear Applicant:

Wheels of Power is a charitable program of the Rotary Club of Portland. Our mission is to provide mobility to low-income, disabled individuals to enable people to participate more fully and independently in the community. Certain eligibility criteria must be met before an application can be fully considered.

The Wheels of Power program has a limited territory. You must reside in one of the following zip code areas in order to apply:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 97005 | 97006 | 97007 | 97008 | 97015 | 97027 | 97030 | 97034 | 97035 | 97201 | 97202 | 97203 |
| 97204 | 97205 | 97206 | 97207 | 97208 | 97209 | 97210 | 97211 | 97212 | 97213 | 97214 | 97215 |
| 97216 | 97217 | 97218 | 97219 | 97220 | 97221 | 97222 | 97223 | 97224 | 97225 | 97227 | 97229 |
| 97230 | 97231 | 97232 | 97233 | 97236 | 97239 | 97242 | 97266 | 97267 |  |  |  |

Please complete this application in as much detail as possible since a lack of information can slow down the process or potentially lead to a denial.

Your application cannot be considered without a provider’s prescription, along with details of your case. The doctor’s information, either on page four of application and/or on separate documents, must include:

1. Medical condition(s) and diagnosis

2. Prognosis

3. Equipment needed

4. Medical necessity of the equipment

Once your application is complete, please send it back and you may be contacted by phone if additional information is needed. If your application is accepted then a specialist will come to your residence in order to fit you for the device. The application and specific device information is then forwarded to the committee for consideration and an additional visit to your residence may take place in order to ask for more detail on the application questions. Please note the review process can take anywhere from two to four months after the complete application is received.

Mail application to: Fax to:

Rotary Club of Portland -or- 503.226.7048

1155 SW Morrison St., Suite 200 Scan to:

Portland, OR 97205 info@rotarypdx.org

**Wheels of Power Application**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received a power chair or scooter through Wheels of Power before? \_\_\_\_\_\_\_\_\_

If so, was it within the last five years? \_\_\_\_\_\_\_\_

**General Applicant Information**

Applicant Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents or Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_

**Environment Situation**

Is your home accessible for a power chair/scooter? Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

Please explain (ex. Ramps, lifts, wide enough doorways). If not, what are your plans for use of wheelchair or scooter?

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

Do you use other orthopedic equipment currently (ex. Walker, cane, manual wheelchair)? If so, what problem(s) do you currently encounter in your home by using this equipment?

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

What method of transportation do you use outside of your home (car, van, public transit, etc.)?

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

How long will you need a power chair/scooter?

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

Do you have assistance with your daily needs? (ex. Family, friends, caretaker) If so, what types of tasks do they assist with? (ex. Errands, medical care, household chores, etc).

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

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

How would increased mobility from access to an electric wheelchair/scooter improve your quality of life? Please include as many examples as possible. Feel free to use an additional page if needed. (ex. Errands, work, school, community, time/activities with friends and family)

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

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

**For Fitting Purposes**

Height \_\_\_\_\_\_ Weight \_\_\_\_\_\_ Are you needing a powered wheelchair \_\_\_ or a scooter \_\_\_?

**Household & Financial Information**

Medical Insurance: Yes \_\_\_ No \_\_\_

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

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

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently employed? Yes \_\_\_\_No\_\_\_\_

If yes:

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark 0 for any that do not apply.

|  |  |  |  |
| --- | --- | --- | --- |
| **Monthly Income** | **Amount** | **Monthly Expenses** | **Amount** |
| SSI/SSDI |  | Rent/Mortgage |  |
| Work |  | Living Expenses (i.e. food, etc) |  |
| Family/Other Assistance  Source: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Utilities, other |  |
| Other Gov. Assistance (i.e. SNAP) |  | Vehicle Expenses |  |
| Other:  Source: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Debt/Payments  Source: \_\_\_\_\_\_\_\_\_\_\_ |  |
| **Total** |  | **Total** |  |

Any other financial information you would like to include that is not outlined above:

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

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

Upkeep of motorized wheelchairs and scooters typically costs $250-$500 per year. Would you be able to afford these costs? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If your monthly expenses are currently more than your income how do you plan to pay for upkeep?

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

I certify that the above statements are true and that no information known to me has been omitted. I authorize you to retain this information whether or not I receive a chair/scooter from the Rotary Club of Portland.

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

Applicant Signature Date

**If application completed with assistance:**

I certify that the above statements are true to the best of my knowledge and that no information known to me has been omitted. I authorize you to retain this information whether or not applicant receives a chair/scooter from the Rotary Club of Portland.

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

Contact Name Phone number

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

Contact Signature Date

**TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER**

**Fax to: 503.226.7048 or email to info@rotarypdx.org**

**Rotary Club of Portland - Wheels of Power**

**PO Box 28106  
Portland, OR 97228**

**Prescribing and Attending Provider:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. Prescription for:

□ Power Chair Only

□ Power Scooter Only

□ Either Chair or Scooter

□ Needed Accessories:

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

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

b. Description of medical condition(s) and diagnosis:

c. Description of current physical condition:

d. Provider’s statement of need for prescribed item:

**\*\* You may attach additional pages for thorough information \*\***

If information is completed on this page, sign below.

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

Prescribing/Attending Provider Signature Date