

# ALTERNATIVES IN MOTION

## Application for Services

Complete the following 2 page application. When submitting your application, also include copies of the following for verification of medical and financial need:

- A copy of physician's prescription or a letter of necessity from physical therapist or physician
- Quote from a wheelchair vendor describing the wheelchair needed and its estimated cost
- Insurance carrier's denial for this wheelchair
- A copy of applicants' most recent tax return or other verification showing total annual income

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Rent or Own Home \_\_\_\_\_ Male / Female \_\_\_\_\_  
Street Apt # (circle one) (circle one)

City State Zip County Birthdate: \_\_\_\_\_

Telephone # \_\_\_\_\_ Telephone #2 \_\_\_\_\_  
Home Cell or Work

### FINANCIAL ASSESSMENT

#### MONTHLY HOUSEHOLD INCOME:

Wages: \_\_\_\_\_

SSI/SSDI: \_\_\_\_\_

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

(specify) \_\_\_\_\_

**Income Total:**

#### ASSETS:

Savings \_\_\_\_\_

Checking \_\_\_\_\_

Stocks/Bonds \_\_\_\_\_

Other \_\_\_\_\_

(specify) \_\_\_\_\_

#### MONTHLY HOUSEHOLD EXPENSES:

Rent/Mortgage: \_\_\_\_\_

Utilities: \_\_\_\_\_

Food: \_\_\_\_\_

Clothing \_\_\_\_\_

Auto Pmt/Exps: \_\_\_\_\_

Insurance \_\_\_\_\_

Medical Expense: \_\_\_\_\_

Other \_\_\_\_\_

(specify) \_\_\_\_\_

**Expense Total:**

#### LIABILITIES:

Medical Bills \_\_\_\_\_

Credit Cards \_\_\_\_\_

Mortgage \_\_\_\_\_

Other \_\_\_\_\_

(specify) \_\_\_\_\_

OTHER: Marital Status: \_\_\_\_\_

# of Dependents: \_\_\_\_\_

List ages: \_\_\_\_\_

Employer Name \_\_\_\_\_

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

### WHEELCHAIR REQUEST INFORMATION

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Briefly describe your disability \_\_\_\_\_

Describe the wheelchair being requested \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Expected Cost: \_\_\_\_\_

Describe how this wheelchair will benefit you (at home, at work and in the community) and what barriers it will help you overcome: \_\_\_\_\_  
\_\_\_\_\_

Do you own a similar wheelchair? **YES / NO**  
(circle one)  
IF YES, why does this wheelchair require replacement? \_\_\_\_\_

Who has been involved in your evaluation for a wheelchair? (i.e.: physical therapist or physician) \_\_\_\_\_

Do you have health insurance? **YES / NO** IF YES, please fill in the following information:  
(circle one)  
Insurance Carrier \_\_\_\_\_ ID# \_\_\_\_\_  
Name  
Address City State Zip

Has your insurance carrier denied this expense? **YES / NO**  
(circle one)  
What other agencies have you applied to for financial aid and what was their response? \_\_\_\_\_

The above information is complete and correct to the best of my knowledge.  
Alternatives in Motion will not be held responsible for any injury, harm or damage to oneself, others or property during the recipient's use of this chair.

\_\_\_\_\_  
Signature Date

**Photo and News Release:**

I authorize Alternatives in Motion to use photographs and information about me for promotional and news release purposes.

\_\_\_\_\_  
Signature Date

**Please submit your completed application along with verification copies**  
**By mail to: Alternatives in Motion** **By fax to:**  
**201 Matilda NE** **616-493-2621**  
**Grand Rapids, MI 49503**  
**If you have any questions, please contact our office at:**  
**616-493-2620 or Toll free: 877-468-9335**