Ground Floor, Sable Corner
15 Bridgeway Road
Bridgeways Precinct
Century City
7441

APPLICATION FOR A MOTORIZED WHEELCHAIR or other appliance

PLEASE READ THROUGH THOROUGHLY AND COMPLETE WITH AS MUCH DETAIL AS POSSIBLE

(The Fund aims to assist **the neediest** people with essential appliances not funded by other sources. It should be considered as a **last resort** for funding**.)**

(The form can be completed **(as fully as possible)** by the applicant or an organization or other authority familiar with the applicant, **with supporting information on the organization's letterhead.)**
Supporting information required is: A detailed motivation/report from a medical professional and a quote if possible for the appliance. If the form is filled out by hand, please write very clearly.

APPLICANT'S DETAILS

Name: .....ID No: ..... Today's Date: .....
(Please enclose a clear copy of the Client's identity document or birth certificate)

Age: .....Tel. No. ..... Email.....

Address.....
..

City or Town: ..... Rural ☐

Province:

Postal Code:

Race: Black ☐ White ☐ Coloured ☐ Asian ☐ Indian ☐

Language:

Referred to Rachel Swart Fund - by whom?

The person making the application:

Physiotherapist ☐ Name: .....

Occupational Therapist ☐ Name: .....

Social Worker ☐ Name: .....

Doctor ☐ Name: .....

Recipient self-initiated application ☐

PLEASE READ THE POLICY BELOW BEFORE FILLING OUT THE FORM:

POLICY OF THE RACHEL SWART FUND IN TERMS OF BEING A LAST RESORT

The Rachel Swart Fund (RSF) is an organisation that provides mobility aids to severely disabled people throughout South Africa. The Fund aims to assist people from disadvantaged communities who are not able to obtain these devices due to their current socio economic circumstances. There is a specific focus on provision of Motorised Wheelchairs to eligible individual's in order to improve their quality of life and autonomy, and with the knowledge that state services are not always able to provide such devices. The Fund offers support to patients accessing services via the public health sector. This is as a last resort due to the fact that the provision of mobility aids remains the responsibility of the public health system.

Whilst the RSF remains sympathetic to the challenges within government hospitals, application through the Fund will only be considered after documentation of an application through the existing public health sector channels can be provided. This process ensures that the Department of Health continues to realize the need for mobility aids for people living with disabilities who are dependent on government services for their mobility devices.

Adherence to this policy will assist the RSF in providing assistance to individuals requiring devices which are unlikely to be provided for by the State.

IF YOU ARE APPLYING FOR A **KAYE WALKER, WALKING FRAME, STANDING FRAME, AFO'S** ETC PLEASE IGNORE QUESTIONS 7a, 10a, 10b, 13b, 15 and 17 ALL THE REST APPLY.

1. Description of disability (e.g. Paraplegic, quadriplegic, etc.)

   Quadriplegic ☐

   Paraplegic ☐

   Hemiplegic ☐

   Amputee ☐

   If other, specify disability .....

1a. Medical diagnosis (e.g. Muscular Dystrophy, CP or spinal injury, etc.) and is the disability permanent?

..... add the medical code

2. Cause of injury (when applicable) e g motor vehicle accident, diving, etc.

.....

3. The hospital where treatment was received.....

Is applicant still receiving therapy? .....

Is the applicant a state patient? .....

4. Does **the applicant** earn an income or receive a grant?*

Specify which grant and how much is received.....

Indicate **household** income:

Less than R 1000 ☐ Between R 1000 and R 3000 ☐

Between R 3000 and R 10 000 ☐ Between R 10 000 and R 25 0000 ☐

More than R 25 0000 ☐

***Please indicate earnings above of the main carer (parent or guardian) of the applicant should they be under age, a student or not able to work due to their disability.**

Circle applicant's public hospital Uniform Patient Fees Schedule (UPFS) rating

H0	**H1**	**H2**	**H3**	**Private/WCA/RAF**

- **Is the applicant on medical aid? Please give details and has the medical aid been approached for assistance?**

  .....

5. Appliance/assistive device requested (e.g. motorized wheelchair, cushion, etc.)

5a) if applying for a motorised wheelchair please confirm that the client is capable of independently handling a motorised wheelchair. Describe their cognitive level.

6. Is the device being applied for (or an equivalent) available via the state public health facilities? **(See Policy Pg. 2)**

Yes ☐

No ☐

7. Has an attempt been made to get the item through the public health facility? **PLEASE PROVIDE EVIDENCE THAT CLIENT IS ON A WAITING LIST AT A GOVERNMENT HOSPITAL. (See policy pg. 2)**

Please note that clear specifications for the appliance will be required, to be done by a physiotherapist or occupational therapist (e.g. Width of chair, cushion, which side control, etc., any other special requirement.)

a) Has the person doing the assessment been trained in seating, if applying for a wheelchair, manual or motorized? .....

b) Make sure that the motivation for the applicant is not from the supplier of the device. E.G. Shonaquip or CE Mobility.

8. Supplier of the appliance (if known) .....

9. Quote for appliance (if available, attach a copy) .....

PLEASE NOTE THAT THE MAXIMUM AMOUNT THAT CAN BE APPLIED FOR IS R 40 000, 00. ANYTHING OVER THIS AMOUNT WILL HAVE TO BE COVERED BY THE CLIENT.

10. Where else was **financial assistance** for the appliance applied for (e.g. Government hospital, medical aid, service club, church, corporate donors, etc.) And what was the result? **REMEMBER THE FUND IS A LAST RESORT AND OTHER FUNDING ATTEMPTS MUST BE MADE FIRST BEFORE COMING TO THE RACHEL SWART FUND (See policy on pg.2)**

10a) was any claim for compensation made (e.g. Road Accident Fund, WCA, etc.)?

RAF Claim no. Or Reference no…….

10b) if so, what is the current position or give contact details of a lawyer or representative?

……

11. Give information on the applicant's financial situation and motivation why the Fund should assist financially**: (if the applicant is under age give parent or guardian details)**

12. Is the applicant able to work? If not please explain

13. a) Is the applicant employed at the moment? If yes, give details of where and what the employment is**. If the applicant is still at school give details.**

b) If the applicant is not employed will they be able to seek employment after receiving the device being applied for? If employment is not possible explain why?

14. Besides employment, what will the **impact be on the client** receiving the mobility aid? What will they be able to do that they could not do before?

What will the **impact be on the carer of the client** receiving the mobility aid?

15. **Describe t**he applicant's **home and or work environment**, if applying for a manual or motorized wheelchair.

Is it wheelchair accessible?

If applying for a motorized wheelchair is there electricity?

Describe the condition of the roads and or terrain that the client will be using. Is it suitable for the chair?

16. Who cares for the applicant? Does the applicant live alone or with family, or in a residential home? Explain this in full giving as much detail as possible regarding the **applicant's family and home circumstances.**

16 a) Is the applicant, or other supporters (family and friends), in a position to contribute any amount to the cost of the appliance? If so, please indicate amount.
(We will accept as little as R50 / R100 per month or once off donations of R500 / R1000. The contributions will be used to help more people in the future. The client needs to understand that the device being applied for will from time to time need maintenance, these contributions will also help towards these costs.)

17. If the applicant is paraplegic and is applying for a motorized wheelchair, please explain clearly why the applicant has applied for a motorized wheelchair instead of a manual chair. **This will have to be motivated by a medical professional.**

Please give any other relevant information.

Name in print of the person who filled out this form

Signature: .....

Contact telephone number..... Email address.....

Please indicate your connection to the applicant.

DECLARATION: I, _____ understand that should I receive a Mobility Aid from the Rachel Swart Fund I will take very good care of it and that I may not sell it. Should anything happen to me, arrangements will be made for the device to be returned to the fund.

SIGNATURE: _____ DATE: _____

I, _____ give the Rachel Swart Fund permission to use the information given in this application to report to donors and to use for statistical purposes.

Name: _____ Signature: _____

Guardian: _____ Signature: _____

CHECKLIST:

PLEASE ENSURE THAT ALL OF THE SUPPORTING DOCUMENTS ARE ATTACHED TO ENSURE THE SUCCESS OF YOUR APPLICATION.

FULLY COMPLETED APPLICATION FORM	
A DETAILED MOTIVATION FROM EITHER AN OCCUPATIONAL THERAPIST OR PHYSIOTHERAPIST. **PLEASE INCLUDE IN THIS MOTIVATION THE CLIENTS EXPECTATION OF THE MOBILITY AID**	
COMPLETE SPECIFICATIONS OF THE MOBILITY AID BEING APPLIED FOR	
A QUOTE	
EVIDENCE THAT THE CLIENT IS ON A GOVERNMENT HOSPITAL WAITING LIST (IF APPLICABLE).	
CLIENT'S ID or BIRTH CERTIFICATE WITH PARENT/GUARDIAN ID	