APPLICATION FOR AN ASSISTIVE DEVICE

NPO: 002-955 | PBO: 130000896

Our policy: The Rachel Swart Fund helps people with disabilities get the assistive devices they need when no other funding is available. Providing assistive devices is the responsibility of the public health system, so we fund only as a last resort. The client must first apply through a state hospital or clinic, and we need proof of that application. We can fund up to R50 000 per application. Anything over this amount must be covered by the client.

Please complete this form as fully as possible. If you need more space for any answer, use the Additional information page (page 5).

Please submit the completed application and all supporting documents to info@rachelswart.org.za

1. PERSON COMPLETING THIS FORM

Who is completing this form?	☐ The client ☐ Family member / carer ☐ Professional (e.g. social worker, therapist)		
Today's date		**Name**	
Phone		**Email**	
Organisation (professionals only)		**Job title (professionals only)**	

2. CLIENT DETAILS

First name		**Surname**	
SA ID number or passport number (non-SA)		**Date of birth**	
Gender	☐ Female ☐ Male	**Race**	
Home language		**Phone**	
Email		**Rural area?**	☐ Yes ☐ No
Street address		**Suburb**	
City / town		**Province**	
Postal code		**Country**	

3. HEALTH

Description of disability	☐ Quadriplegic ☐ Paraplegic ☐ Hemiplegic ☐ Amputee ☐ Other:
Medical diagnosis	*(e.g. cerebral palsy, spinal cord injury, muscular dystrophy) - add the ICD-10 code if known. Is the disability permanent? If you need more space, use page 5.*

Year of diagnosis / injury		**Cause of injury (if applicable)**	
Hospital where treatment was received			
Still receiving therapy?	☐ Yes ☐ No	**State patient?**	☐ Yes ☐ No
UPFS rating	☐ H0 ☐ H1 ☐ H2 ☐ H3 ☐ Private / WCA / RAF		
On medical aid?	☐ Yes ☐ No	**Medical aid name**	
If yes: has the medical aid been asked to fund this device? What was the outcome?	*(If you need more space, use page 5.)*		

4. DEVICE REQUESTED

Type of device	☐ Motorised wheelchair ☐ Manual wheelchair ☐ Buggy ☐ Cushion ☐ Other:		
Make and model		**Supplier (if known)**	
Quote amount	R	**Has the client applied for this device through a state facility?**	☐ Yes ☐ No
If yes: date applied		**Facility**	
Why is the state not supplying this device?	*(Attach evidence that the client is on a government hospital waiting list, if applicable. If you need more space, use page 5.)*		

5. FINANCIAL AND HOME SITUATION

Does the client receive a grant?	☐ Yes ☐ No	**Type of grant**	
Grant amount per month	R	**Number of people in the household**	
Monthly household income	☐ Less than R1 000 ☐ R1 000 - R3 000 ☐ R3 000 - R5 000 ☐ R5 000 - R10 000 ☐ R10 000 - R25 000 ☐ More than R25 000		
Client employment status		**Compensation claim made (e.g. RAF, WCA)?**	☐ Yes ☐ No Ref no:
If yes: claim status and lawyer / representative contact details			

Where else has financial assistance been applied for, and what was the result?	*(e.g. government hospital, medical aid, service club, church, corporate donor) If you need more space, use page 5.*
Household financial situation	*(Any additional information about the household's finances. If you need more space, use page 5.)*
Living situation	*(Does the client live alone, with family, or in a residential home? Does anyone help care for them? Give as much detail as possible. If you need more space, use page 5.)*
Home / work environment and terrain	*(Describe the home, roads and terrain the device will be used on. If you need more space, use page 5.)*

Is the home wheelchair accessible? (wheelchair only)	☐ Yes ☐ No	**Electricity at home? (motorised only)**	☐ Yes ☐ No

6. CONTRIBUTION

We ask clients and their families to contribute towards the cost of the device, however small. We accept as little as R50 or R100 a month, or a once-off amount of R500 - R1 000. Contributions help us to assist more people. All devices need maintenance from time to time, and contributions also help cover these costs.

Contribution offered	R	**Payment**	☐ Once-off ☐ Monthly

7. ASSESSING THERAPIST

Name		**Profession**	
HPCSA number		**Place of work**	
Phone		**Email**	
Trained in seating? (wheelchair only)	☐ Yes ☐ No		

8. THERAPIST'S MOTIVATION

Please attach a written motivation from the assessing therapist. It must include a detailed explanation of the following:

1. **Clinical history** - diagnosis, when it started or happened, how the condition has progressed, and whether it is being actively managed (e.g. regular clinic, specialist or therapy follow-up).
2. **Other conditions and medications** - any other health conditions, whether these are being actively managed, and current medication.
3. **Current mobility and function** - how the client moves now, what they can and cannot do independently, and any current device and its condition.
4. **Secondary health risks** - risks to the client's health without the device (e.g. pressure sores, contractures, posture deformity, falls, isolation).
5. **The device recommended and why** - why this specific device suits the client, with full technical specifications (measurements, seating, accessories).

6. Impact of the device - on the client's independence, schooling, employment and participation in the community, and on their carer. Include what the client expects the device to do for them.

7. Motorised wheelchairs (motorised only) - confirm the client can handle a motorised wheelchair independently and describe their cognitive level. If the client is paraplegic, explain why a motorised rather than a manual wheelchair is needed.

The motivation must be signed by the therapist and show their name, profession, HPCSA number and date. Note: the motivation must not come from the supplier of the device (e.g. Shonaquip or CE Mobility).

9. DECLARATION AND CONSENT

☐ **I confirm that:**

- I have read the policy on page 1 and understand that the client must apply through the state first.
- The information in this form is true and correct.
- The Rachel Swart Fund may store this information securely and use it to assess the application, improve its services and report to donors. Information that identifies me will be kept confidential unless I agree otherwise.
- If I receive an assistive device, I will look after it and will not sell it. If it is no longer needed, it will be returned to the Fund.

Client name			
Client signature		**Date**	
Parent / guardian name (if the client is under 18 or unable to sign)			
Parent / guardian signature		**Date**	
Person completing this form (if not the client or guardian)			
Signature of person completing this form		**Date**	

10. CHECKLIST - PLEASE ATTACH

Documents	☐ Fully completed application form ☐ Therapist's motivation (signed, with HPCSA number, including the client's expectations of the device) ☐ Full specifications of the device ☐ Quote ☐ Evidence that the client is on a government hospital waiting list (if applicable) ☐ Copy of the client's ID or birth certificate (with parent/guardian ID for children)

11. ADDITIONAL INFORMATION

Use this page if you need more space. Write the section number and question before each answer (e.g. "5. Living situation").

Additional information	

Please submit the completed application and all supporting documents to info@rachelswart.org.za