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The Rachel Swart Fund

HELPING PEOPLE WITH PHYSICAL DISABILITIES  
ESTABLISHED 1960

**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 most needy** 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 done on the organisation'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 **Johnny Luwazi** ID No: **7003124455 083** Today's Date: **31/10/2014**  
**(Please enclose a clear copy of the Client's identity document or birth certificate)**

Tel. No. **021 555 8836** Fax No. .... Email.....

Address...**73 Blossom Street, Guguletu**

.....  
.....

Race: Black  White  Coloured  Asian  Indian

Referred to Rachel Swart Fund - by whom? **APD Athlone**

The person making the application:

Physiotherapist  Name: **Janet Murray / Groote Schuur Hospital**  
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.) **Including** medical diagnosis (e.g. Muscular Dystrophy, CP or spinal injury, etc.)

Cerebral Palsy / Quadriplegic .....

Is the disability, permanent or temporary? **Permanent** .....

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

Lack of oxygen at birth .....

3. The hospital where treatment was received

Red Cross Children's Hospital .....

Is applicant still receiving therapy? ... **Attends Groote Schuur Hospital for therapy**.....

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

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

Specify which grant and how much is received..... **Johnny receives a disability grant** .....

If employed indicate income:

Less than R 1000 ..... Between R 1000 and R 3000 ... **Mother earns R 2000 p/m**  
Between R 3000 and R 5000..... Between R 5000 and R 10 000 .....  
More than R 10 000 .....

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

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

**16 inch Motorized Wheelchair with Tess Back System and standard seat cushion**

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

**Therapist to give clear indication that he client is capable to handle motorised wheelchair.**

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)**

**Send us copies of your application**

**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? **Yes** .....
- 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) **CE Mobility Cape Town** .....

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

**PLEASE NOTE THAT THE MAXIMUM AMOUNT THAT CAN BE APPLIED FOR IS R 30 000, 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)**

An application was made to Groote Schuur Hospital, application has been put onto a waiting list. (We need evidence of this.)

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

**If the disability has come about due to a car accident the details requested here are vital**

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)**

Johnny lives with his mother and grandmother in a shack in Guguletu. His mother is a domestic worker and adds to the income with her salary of R 2000. Johnny's disability grant and his mother's earnings cover all their living expenses, food, accommodation, electricity and travel expenses.

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

Johnny is severely disabled he will not be able to work. Johnny is able to communicate with those around him and with the motorized wheelchair he will be a lot more independent. The mobility that the

chair will give him will allow Johnny to move around his community freely and partake in community events and workshops where he can learn basic skills. Johnny's independence will bring great relief to his mother and grandmother as they will have more time to do other things.

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.**

No Johnny is not employed but he does attend community workshops.

- 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?

Johnny's disability restricts him from working in the market place

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?

Johnny will no longer be dependent on his grandmother to push him around. She is getting old and cannot push him now unless it is absolutely necessary and so Johnny is often restricted to being inside all the time. He will be able to visit friends and enjoy independence bringing him freedom and inclusion in his community.

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

The burden of having to push Johnny around will be taken away from his grandmother, she is too old to be pushing him around. She can take better care of herself. She too can visit friends in her community knowing that Johnny is independent and no longer relies on her as much. She may even be able to generate a small income.

15. **Describe** the applicant's **home and or work environment**, if applying for manual or motorized wheelchair.

Is it wheelchair accessible?

Johnny lives in a shack in Guguletu. The shack is small but it can accommodate the motorized wheelchair. It also does have electricity. The area around the shack is very sandy but there are paved roads for him to use when moving around the community.

**If applying for a motorized wheelchair** is there electricity? **Yes**

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

Roads are paved, some areas are not very smooth, and there are no actual pavements.

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.**

Johnny lives with his grandmother and his mother. His mother works all day but the grandmother is at home with him.

16 a) What financial contribution can the applicant or other supporters (family and friends) make to the cost of the appliance?

**(Please understand that a contribution is a necessary part of the application, we will accept as little as R 50 per month or once off donations of R 500 / R 1000. 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. )**

The family is very poor but they will try to contribute R 500 towards the motorized wheelchair. (This amount may need to be paid off in instalments)

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.**

N/A

Please give any other relevant information?

At present Johnny is borrowing an old manual chair that is falling apart and his mobility is very restricted, a motorized wheelchair would be a help to him and his family

Name in print of the person who filled out this form Janet Murray

Signature: .....

Contact telephone number..... Email address... [janet@mweb.co.za](mailto:janet@mweb.co.za) .....

**Please indicate your connection to the applicant.** Johnny's Occupational Therapist, from Groote Schuur Hospital.

**71 Klipfontein Road  
Rondebosch, 7700  
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Newlands 7725  
Phone: 021 689-8376  
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email:rachelswart@absamail.co.za**



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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: \_\_\_\_\_

WITNESS: \_\_\_\_\_

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 FOLLOWING DOCUMENTS ARE ATTACHED TO ENSURE THE SUCCESS OF YOUR APPLICATION.**

<b>FULLY COMPLETED APPLICATION FORM</b>	
<b>A DETAILED MOTIVATION FROM EITHER AN OCCUPATIONAL THERAPIST OR PHYSIOTHERAPIST.  PLEASE INCLUDE IN THIS MOTIVATION THE CLIENTS EXPECTATION FROM THE MOBILITY AID</b>	
<b>COMPLETE SPECIFICATIONS OF THE MOBILITY AID BEING APPLIED FOR</b>	
<b>A QUOTE</b>	
<b>EVIDENCE THAT THE CLIENT IS ON A GOVERNMENT HOSPITAL WAITING LIST.</b>	
<b>CLIENT'S ID</b>	