MOBILITY ANGELS CANDIDACY CHECKLIST ®

Candidate Name: ______________________________ DOB: ___________

- ☐ Candidate Intake Application
- ☐ Past Medical History Form
- ☐ Authorization For Medical Release Form
- ☐ Prescription form Primary Care Physician for "Wheelchair Accessible Vehicle" for Child's Medical Diagnosis and include ICD-10 Code
- ☐ Medical Diagnosis is of Genetic or Neurological Condition
- ☐ Letter Of Medical Necessity (or Form) from Primary Care Physician indicating need for *Wheelchair Lift*
- ☐ Last Physical Therapy Evaluation and Plan Of Care
- ☐ Last Occupational Therapy Evaluation and Plan Of Care
- ☐ Recommendation Form from Current Physical and/or Occupational Therapist
- ☐ Recommendation Form from Current School Teacher
- ☐ Copy of last IEP (Individual Education Program)
- ☐ Video of current method of transferring your child into the car
- ☐ Recent Photo of Child
- ☐ Photo/Copy of Valid Driver License of each Parent/Legal Guardian
- ☐ Photo/copy of front and back of Candidate's and/or Primary Policy Holder's Medical Insurance Card
- ☐ Verifiable Income-Last 2 Years Tax Returns or other verifiable income
- ☐ Candidate uses a wheelchair as primary means of mobility *(verified through Physician Letter Medical Necessity, Prescription, Evaluations, Therapist LMN, IEP, Teacher LMN)*

Please send an email to lpalmer@mobilityangels.org to request forms.